258441

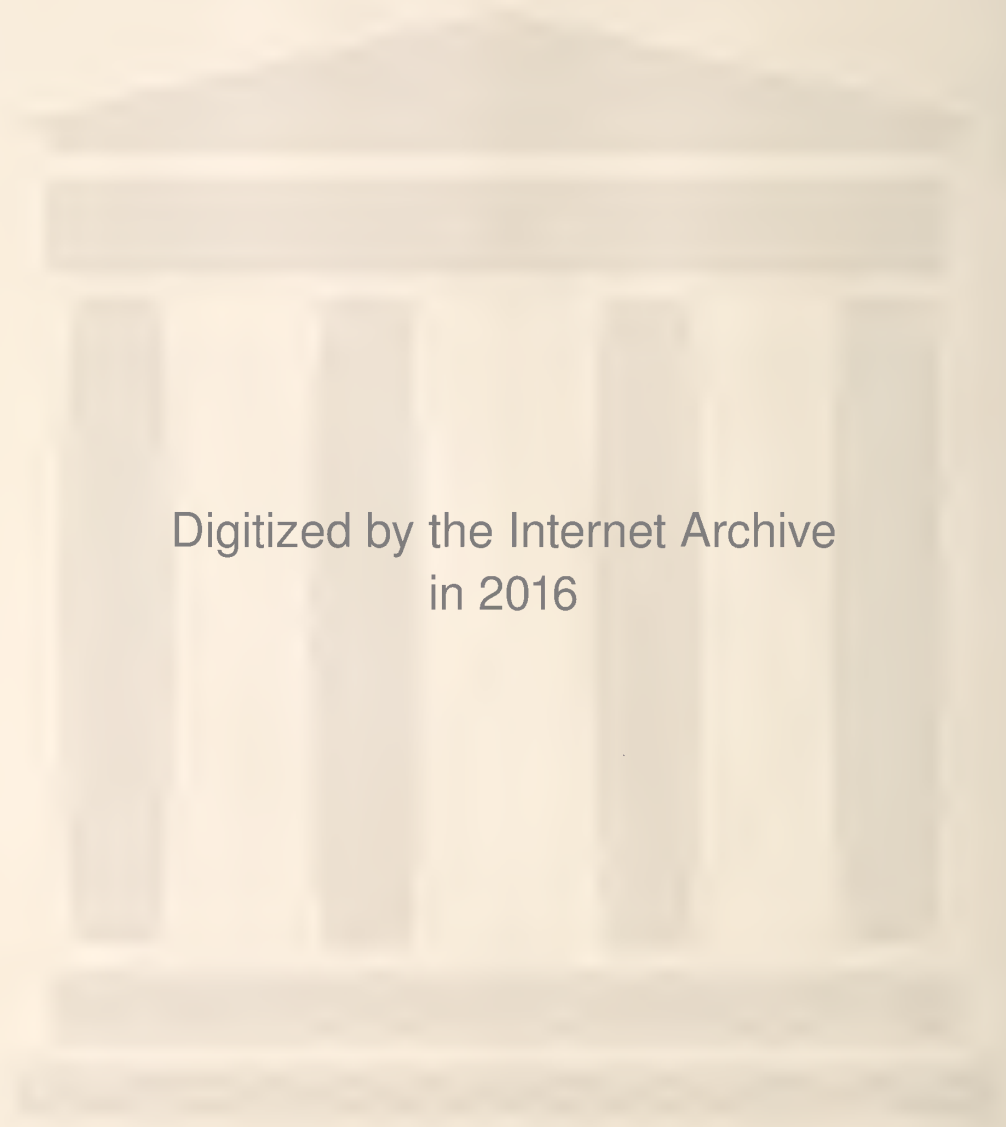


Class Journal No.

LIBRARY GENERAL FUNDS

Luther S. Bent
Binding Fund
William T. Carter
Catalogue Endowment
Louis A. Duhring
W. V. & J. M. Keating
Henry Leffman
Library Endowment
Morris Longstreth
Phila. Med. Society
Charles H. Vinton
Douglas Stockton Warren
J. William White
Caspar Wistar

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA



Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofkentuck6719kent

VOLUME 67 JANUARY 1969 NUMBER 1

The Journal of The KENTUCKY Medical Association

COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JAN 2



In This Issue

Tuberculosis Eradication?
N. A. Saliba, M.D. 33

Treatment of Non-Tuberculous Empyema
Porter Mayo, M.D. and Richard B. McElvein, M.D. 40

An Evaluation of the Therapeutic Efficacy of Intravenous Local Anesthetics
Ronald W. Dunbar, M.D. and Peter P. Bosomworth, M.D. 42

Laryngeal Blastomycosis
Edward J. Fadell, M.D., George I. Uhde, M.D. and Charles C. Smith, M.D. 53

Special Article

What Has the AMA Ever Done for You?
David B. Weihaupt 55

Complete Contents on page 4

KMA INTERIM MEETING
March 26-27
Continental Inn—Lexington



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units). Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

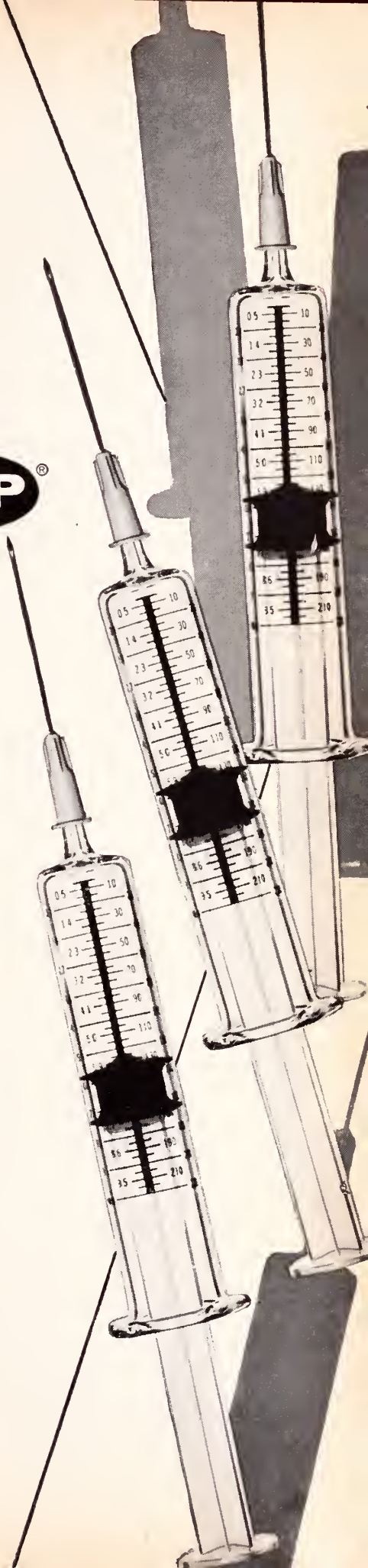
(potassium phenoxymethyl penicillin) Wyeth

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSP03)

BALTIMORE, MARYLAND 21201

258441
MAY 24 1971

Volume 67 • January 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Cae, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Rabert G. Cax

• ASST. MANAGING EDITOR
Peggy Raberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Baak Reviews
Oscar J. Hayes, M.D., Case Discussions
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1971

McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970

Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D
Peggy J. Howard, M.D
Roy A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
John H. Willard, M.D.

Term Expires July 1, 1969

Paul E. Lett, M.D.
David A. Orrihood, M.D.
Harry A. Hamilton, Jr., M.D.
Leslie W. Blakey, M.D.
Raymond J. Timmerman, M.D.
William H. Gillespie, M.D.
J. J. Sonne, M.D.
John L. Creech, Jr., M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Cade 502) 454-6324

Subscriptian $10.00—single capy 1.00
Second-class postage paid at Louisville, Kentucky Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Tuberculosis Eradication?
N. A. Saliba, M.D. 33

Treatment of Non-Tuberculous Empyema
Porter Mayo, M.D. and Richard B. McElvein, M.D. 40

An Evaluation of the Therapeutic Efficacy of Intravenous Local Anesthetics
Ronald W. Dunbar, M.D. and Peter P. Bosomworth, M.D. 42

Laryngeal Blastomycosis
Edward J. Fadell, M.D., George I. Uhde, M.D. and Charles C. Smith, M.D. 53

SPECIAL ARTICLES

What Has the AMA Ever Done for You?
David B. Weihaupt 55

EDITORIALS

Tuberculosis Eradication in Kentucky
R. E. Mardis, M.D. 59

A Face Lifting at Sixty-Six
Walter S. Coe, M.D. 60

SPECIAL FEATURES

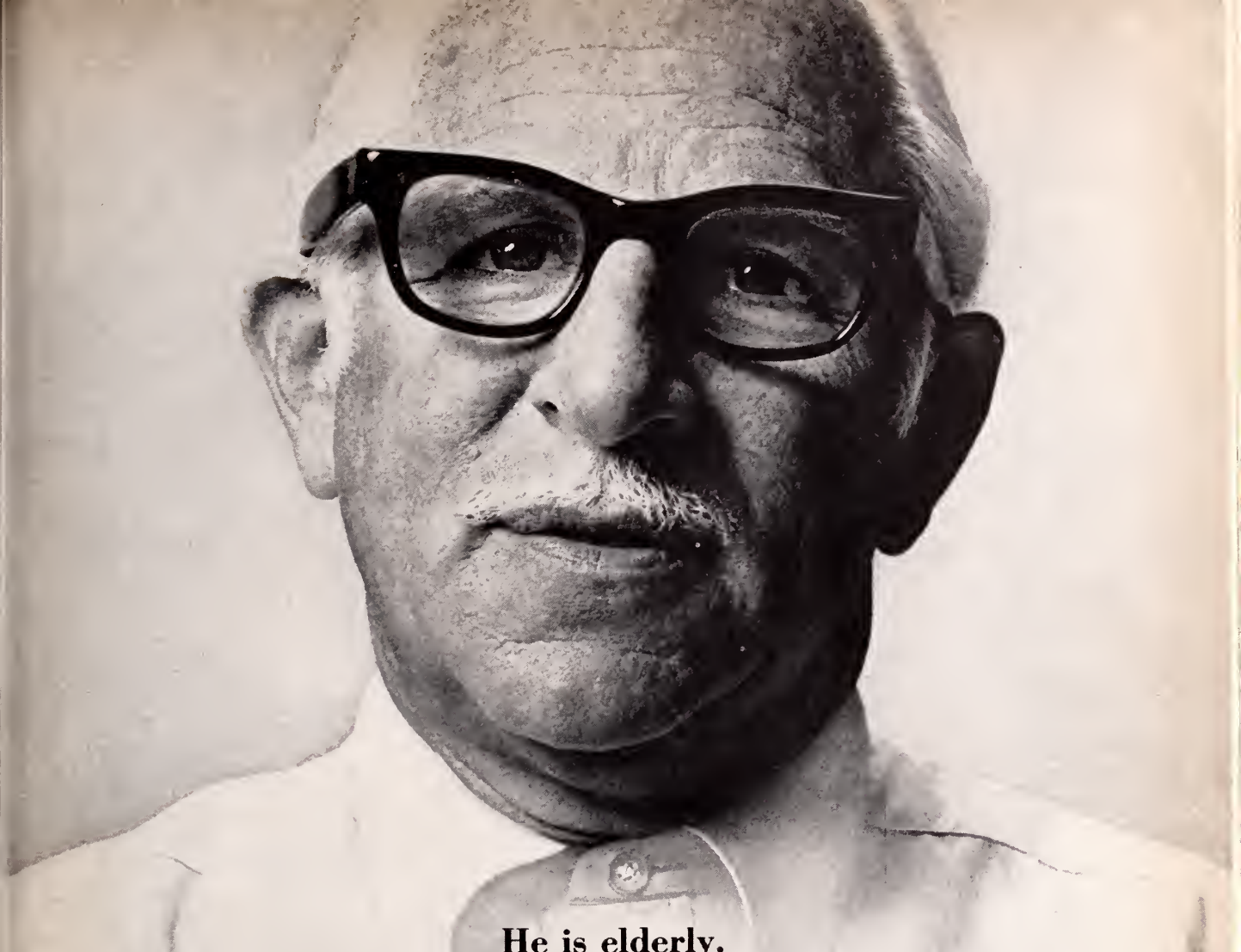
KMA Organizational Chart 24

ORGANIZATION SECTION

Governar Nunn To Deliver Keynate Address At Opening Session Of 1969 KMA Interim Meeting March 26-27 in Lexington 67
First Trustee District To Meet January 22 in Paducah 67
U af L Oral Cancer Symposium Ta Be Presented February 8 67
ACS Sectianal Meeting To Be In Lauisville Feb. 24-26 68
AMA Hause Acts on 94 Matters During Clinical Canvention 68
Ky. Physician Attendance High At Annual SMA Conventian 68
Know Your Congressmen 70

REGULAR FEATURES

President's Page 6
Maternal Martality Page 10
Blue Shield Page 17
Pastgraduate Oppartunities . . . 21
Public Health Page 22



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN —the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



"Equal, But Different"*

A RECENT University of Kentucky Centennial Conference was entitled "Women: Equal But Different." It gave me occasion to reflect upon the excellence of our state's physicians' wives in the woman's role as pivotal figure in the home, as prime mover in civic service, and as essential associate in the labor force.

Kentucky physicians' wives are truly outstanding as homemakers, as volunteer community leaders and as career women. Among them are the immediate past president of the state Federation of Women's Clubs, the national first vice-president of the League of Women Voters, a Republican national committeewoman, a television personality, a state mother-of-the-year, a nationally known author-journalist, the founder of an international aid organization, the head of a metropolitan home nursing service, a state P.T.A. leader, voluntary health agency workers, numerous churchwomen, and many business and professional women—just to mention a few which come quickly to mind because of their current prominence. Certainly our doctors' wives are making contributions to our society which are the equal of any like sized group of women in the state.

We are not only equal, but also different. This distinctive difference stems from our good fortune to serve the medical profession, and thereby to share a small reflection of the honor of its noble mission. It is the opportunity which is cherished by each of us as physicians' wives—prominent and unheralded alike.

Your state auxiliary is in its forty-sixth year of service to KMA, by participation in support of activities it endorses, and by cultivating friendly relations among physicians' families. All WA-KMA functions and those of the 29 organized county auxiliaries are directed at strengthening the medical profession.

I trust you will continue to call upon us for support wherever "the woman's touch" seems indicated. We shall strive to continue proud service deserving of the distinct "medical auxiliary" accolade.

MRS. WILLIAM H. MCBEATH, PRESIDENT
WOMAN'S AUXILIARY TO THE KMA

**This is the first in a series of articles written at the request of KMA President Henry B. Asman, M.D.*



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

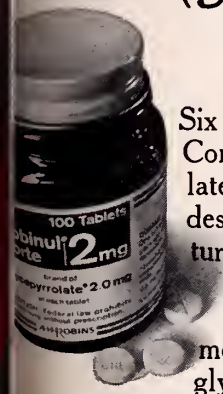
Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information. Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming): Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

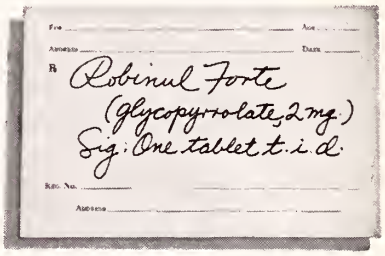
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) ınd good acceptance among numerous physicians, ny others just didn't seem to want to give it a try, ›bably because the anticholinergic they were al-dy using was giving acceptable results.

›wever, we believe you'll agree there's always ›m for a better anticholinergic. This is why we're ting you to give Robinul Forte a fair trial. Robinul rte exerts a highly specific antisecretory action and ırked inhibitory effect on intestinal tone. We're con-ced you'll agree that this is indeed an outstanding ıg when you observe its outstanding suppression of :er symptoms. Furthermore, it is unique in that it luces intestinal tone, yet has little or no effect on ristalsis. In addition, the incidence of the more thersome peripheral side effects is low.

› longer does the physician have to look for extreme y mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 17-67. A 20-year-old, married, white primigravida who had had no prenatal care was admitted at 12:30 a.m. on September 2, 1967, with light uterine contractions. The blood pressure on admission was 110/70. The patient began having stronger uterine contractions at about 2 a.m., and a vaginal examination was performed. The cervix was thinning and dilated to 4 cm, and the presenting part was described as high. A bloody show was noted. The patient received 50 mg of Demerol with 50 mg of Phenergan intramuscularly. The membranes ruptured spontaneously at 2:48 a.m., and the patient was observed to be having a moderate amount of vaginal bleeding. The blood pressure was now 120/90. Vaginal examination at 3 a.m. showed the cervix to be dilated to 7 cm, and the presenting part was low. At 3:25 a.m. the cervix had dilated to 8 cm. The patient was transferred to the delivery room and her physician was called at 3:35 a.m.

She was delivered of a living male infant weighing 8 pounds 2 ounces by low forceps extraction with Trimar analgesia at 4:29 a.m. The placenta was expressed intact. A perineal tear was repaired. The patient was returned to the postpartum floor at 4:45 a.m. in good condition. Her blood pressure was 112/84, and the uterus was firm. She was still sleeping when checked at 5:10 a.m.; the uterus remained firm, but she continued to have a moderate amount of bleeding. At 6 a.m. her blood pressure was 132/90 and her pulse was 74. The uterus was massaged until firm at 6:20 a.m., when the bleeding was described as moderate. At 6:45 a.m. the bleeding was brisk once more; the blood pressure was now 104/84. An ampule of Ergotrate was administered slowly intravenously, and an infusion of 1000 cc of 5 per cent dextrose in water was started. The blood pressure had dropped to 90/70, the uterus was high, and excessive vaginal bleeding continued. The uterus was massaged. The patient was pale and unresponsive. At 8 a.m. the patient's private physician ordered her to be typed and cross matched for blood and issued a call for donors. An ampule of Thytuitary was given intramuscularly. Oxygen was started by mask and a Foley catheter was inserted in the bladder, and the patient was given 50 mg. of Demerol and 50 mg of Phenergan for restlessness; 500 cc 6% Dextran were added to the intravenous infusion, and two ampules of Adrenosen were given intramuscularly. The patient was cold to touch in spite of external heat. Her pupils were dilated and she continued to bleed, passing large clots vaginally.

At 11 a.m., one ampule of Levophed and one ampule of vitamin K were added to the intravenous fluids, and a second ampule of Thytuitary was administered intramuscularly. She continued to pass clots vaginally; her pulse was weak, and her blood pressure was 90/60. At noon her blood pressure was undetectable. Her physician then ordered 4 grams of fibrinogen to be given as soon as available. Her pulse was 164 and very weak. Blood was finally available and started at 1:20 p.m. Her physician administered artificial respiration; but she died at 1:30 p.m. There was no autopsy. From the information supplied, the patient was apparently never returned to the delivery room for re-examination to determine the source of bleeding.

The cause of death was listed as: Term pregnancy, labor, delivery with postpartum hemorrhage, shock and death.

Comments

The Committee classified this case as a direct obstetrical death with preventable factors on the part of the physician. Hemorrhage continues to be one of the principal causes of maternal death, and on its recognition and prompt treatment depends the life of the patient who develops it. Although the protocol suggests that the hemorrhage was probably secondary to uterine inertia, no direct examination was performed to rule out a tear as the source of the bleeding; such an examination should be undertaken as a preliminary measure in all cases of postpartum hemorrhage. Unfortunately for this patient, blood was not immediately available for transfusion, and this circumstance almost certainly decided the outcome. There appeared to be no rationale for ordering fibrinogen in this patient since there was no evidence of a clotting defect. It has been truly stated that the prognosis of a severely bleeding postpartum patient depends in large degree upon what is done within the first 15 minutes after the onset of significant blood loss. All physicians responsible for the management of obstetric patients must be completely familiar with the treatment of acute hemorrhagic emergencies if deaths from this cause are to be prevented.

MARION LABORATORIES, INC.
10236 BUNKER RIDGE ROAD • KANSAS CITY, MISSOURI 64137 • 816-761-2500

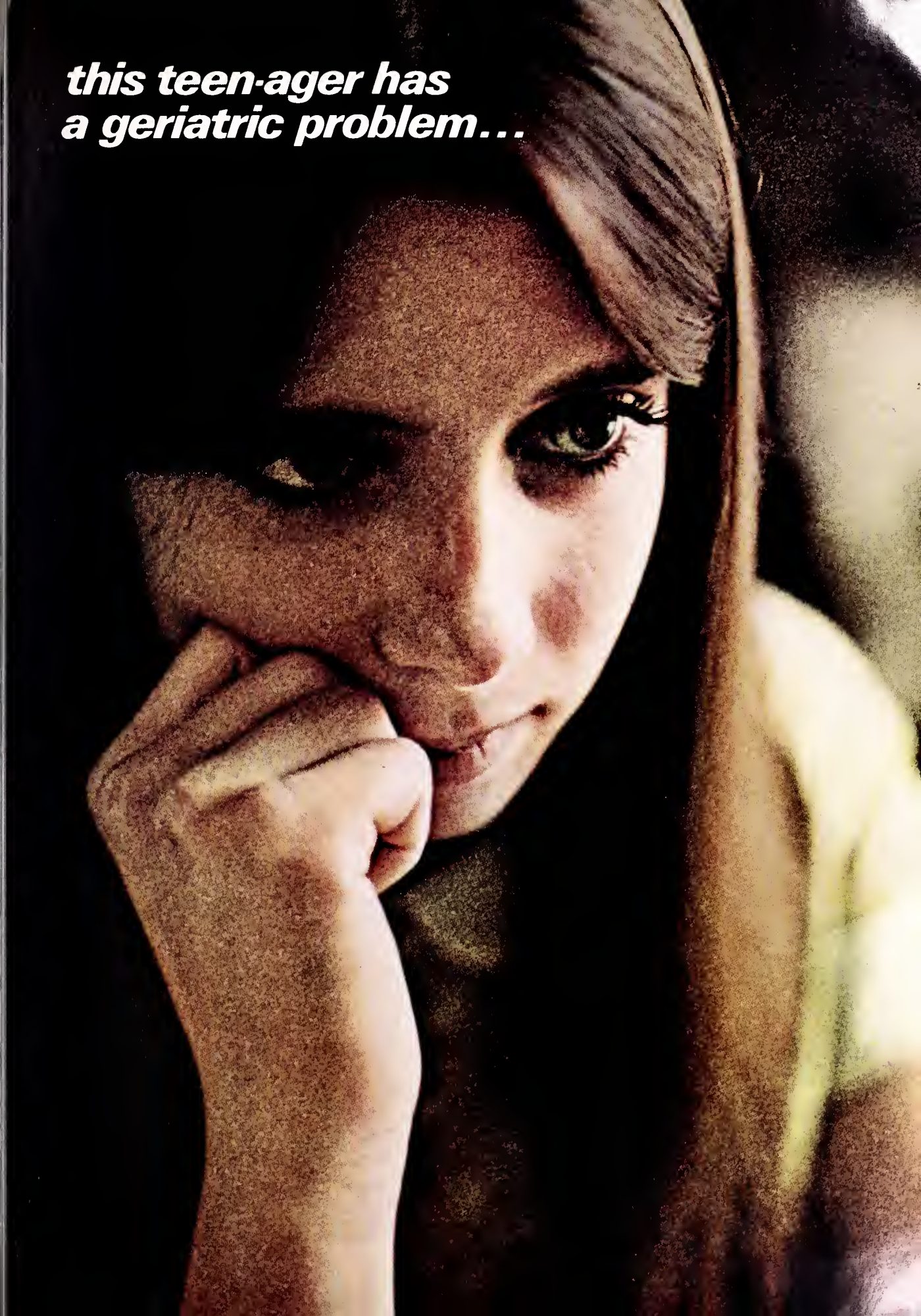
Dear Dr.

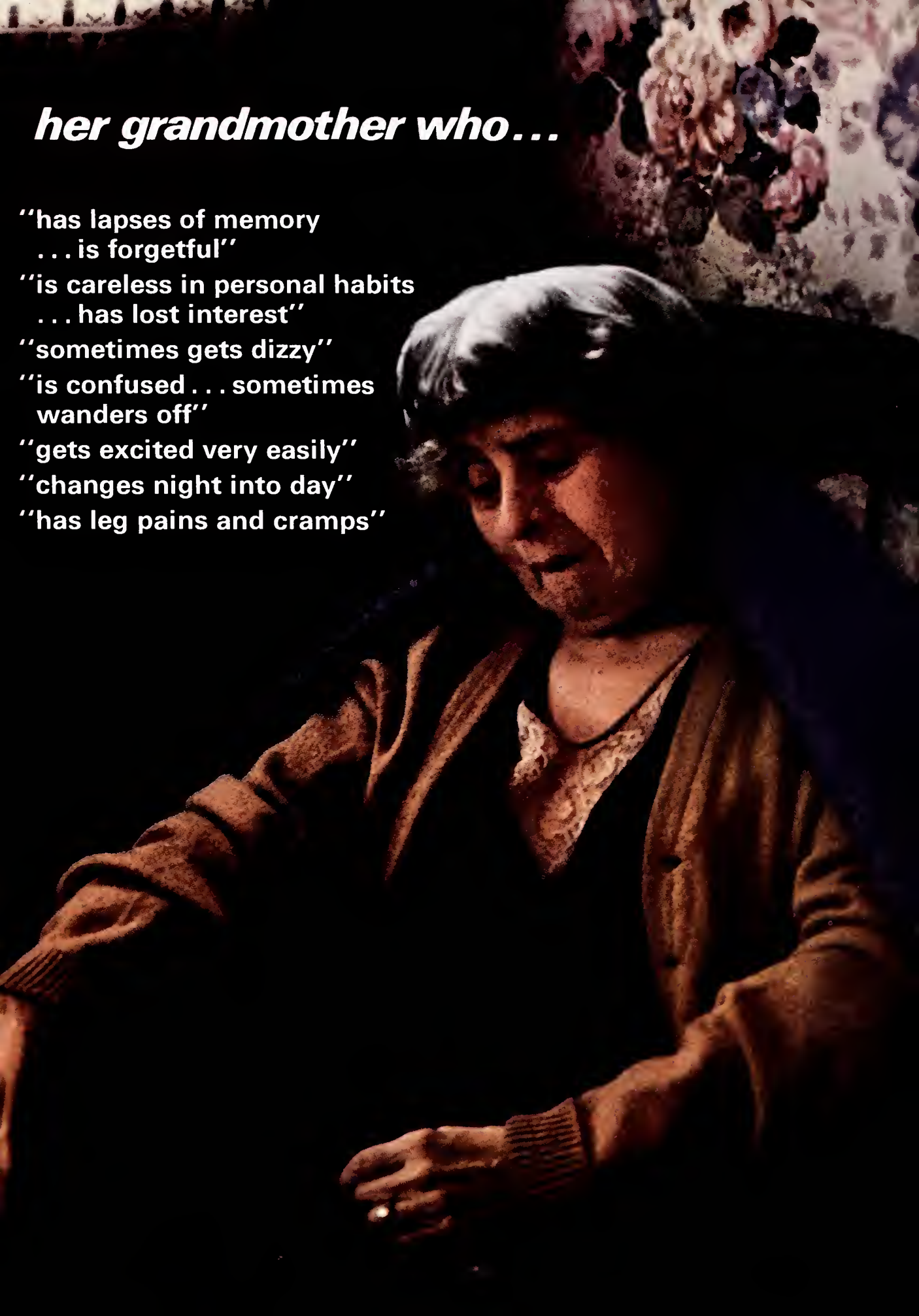
The familiar problem posed in the following three pages is not limited to a patient/physician relationship.

The headline (with an appropriate illustration change) very well could read, "This doctor has a geriatric problem"... if so Pavabid (papaverine H Cl. 150 mg) may help.

If such a problem exists in your immediate family with a father, mother, brother or sister, and you feel Pavabid may be of some help, we have a program that will allow you to meet the Pavabid needs of these persons for as long as the need exists. For more information, please write me personally or call me collect.

Yours very truly,
P A Boyer, M.D.
Medical Director


this teen-ager has
a geriatric problem...


her grandmother who...
"has lapses of memory ... is forgetful"
"is careless in personal habits ... has lost interest"
"sometimes gets dizzy"
"is confused ... sometimes wanders off"
"gets excited very easily"
"changes night into day"
"has leg pains and cramps"

Relief of these symptoms of cerebral and peripheral vascular insufficiency may be "most gratifying" with a regimen of

PAVABID®

(papaverine HCl, 150 mg) b.i.d.

Prolonged action by microdialysis

LaBrecque[1] on Cerebral Ischemia

"Fully realizing the handicap of attempting to evaluate subjective responses, it was definitely concluded that papaverine hydrochloride (Pavabid) proved a valuable aid in the treatment of the mentally confused geriatric patient."

Dunlop[2] on Cerebral Ischemia

"Even in patients in whom the cause of symptoms is in doubt, papaverine (Pavabid) merits consideration as a therapeutic trial. The occasional favorable response in such instances is most gratifying."

Stern[3,4,5] on Peripheral Ischemia

Substantial relief of the symptoms typical of peripheral vascular disease was demonstrated in three double-blind, crossover studies covering 80 patients. A total of 73 patients reported mild, good and excellent symptom relief.

Dunlop[2] sums it up—

"With the return of memory function there was often noted an improvement in energy, ambition and desire to return to a productive life."

Aren't these the therapeutic results most desired in the ischemic geriatric patient?

Give Pavabid Time—LaBrecque suggests two to three months.

A Secure Regimen—with Pavabid you can concern yourself with results, not side effects.

1. LaBrecque, D. C.: Papaverine Hydrochloride as Therapy for Mentally Confused Geriatric Patients, Cur. Ther. Research *8*:106-109 (March) 1966.
2. Dunlop, E.: Chronic Cerebral Vascular Insufficiency Treated with Papaverine, J. Am. Geriatrics Soc. (Accepted for publication.)
3. Stern, F. H.: Papaverine in the treatment of Peripheral Vascular Disease, J. Am. Geriatrics Soc. *13*:815 (Sept.) 1965.
4. Stern, F. H.: Leg Cramps in Geriatric Diabetics with Peripheral Vascular Ischemia: Treatment, J. Am. Geriatrics Soc. *13*:609 (June) 1966.
5. Stern, F. H.: Further Evaluation of Papaverine for Peripheral Vascular Ischemia, J. Am. Geriatrics Soc. *15*:386-393, 1967.

Pavabid® Plateau CAPS® (Papaverine HCl, 150 mg)

Each capsule contains papaverine hydrochloride, USP, 150 mg in a special base for prolonged therapeutic effect. Class M narcotic.

Indications: For the relief of cerebral and peripheral ischemia associated with arterial spasm and myocardial ischemia complicated by arrhythmias.

Dosage: One capsule every 12 hours. In difficult cases, administration may be increased to one capsule every 8 hours, or two capsules every 12 hours.

Precaution: Use with caution in patients with glaucoma.

Side Effects: Infrequently reported side effects of papaverine include nausea, abdominal distress, anorexia, constipation, malaise, drowsiness, vertigo, sweating and headache.



MARION LABORATORIES, INC.
Kansas City, Missouri 64137

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

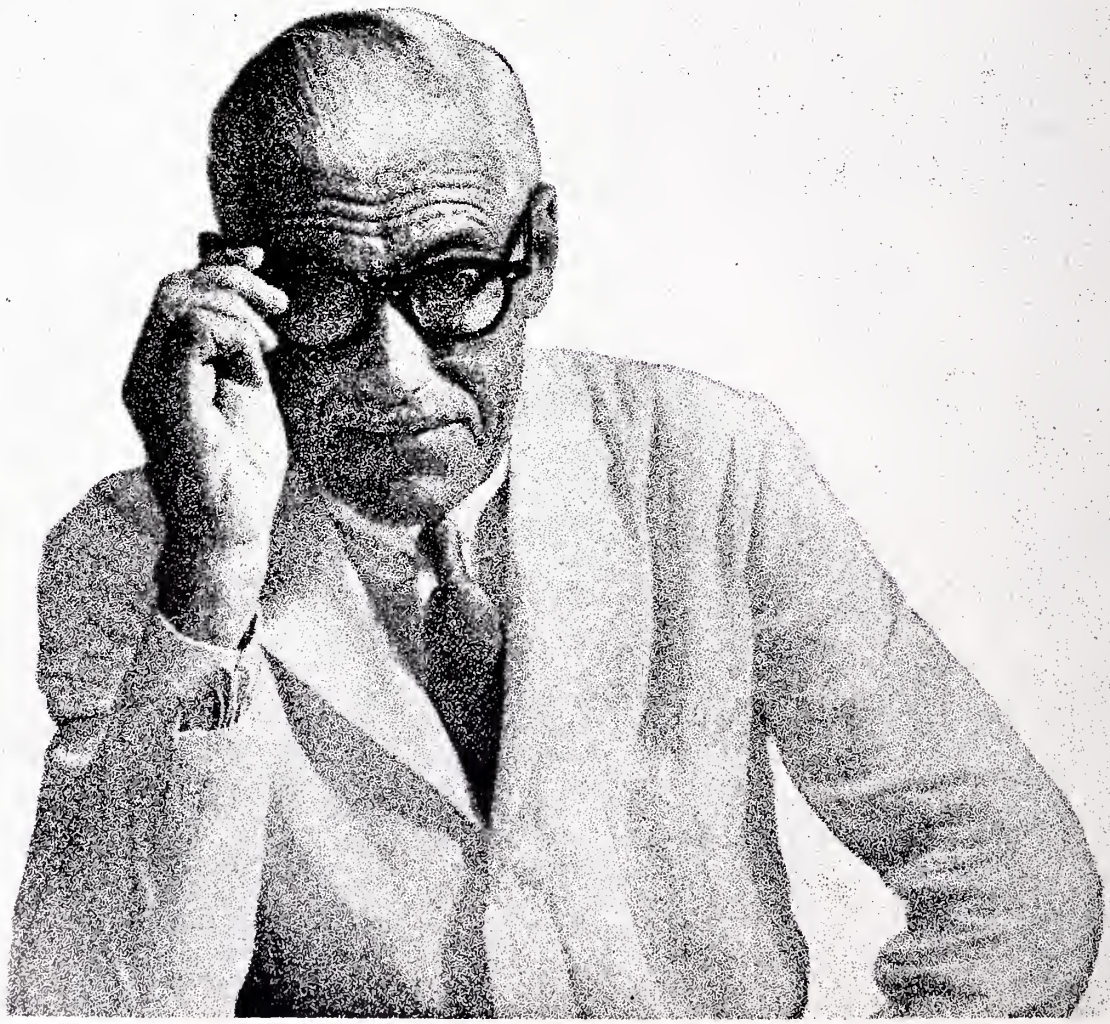
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®





ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

Q. Please define a medical endorsement (rider).

A. A medical endorsement is an addition to the basic Blue Shield Certificate of Membership which provides benefits to a physician for the in-hospital care of a patient for the medical treatment of an illness or injury. The reduction of fractures and/or surgical services would not be covered under these endorsements; however, there would be an allowance for these procedures under the basic Blue Shield coverage.

Q. Do all Blue Shield subscribers have a medical endorsement?

A. Every level of Blue Shield benefits offered to the public includes coverage for in-hospital care, and a great percentage of Blue Shield subscribers have one of these medical endorsements. Since Blue Shield, however, is a voluntary organization, there is a small percentage of Blue Shield subscribers who have chosen not to carry medical endorsement coverage.

Q. How do I determine on a Blue Cross and Blue Shield I.D. card if my patient has a medical endorsement?

A. This determination can be made using the last two digits of the Blue Shield Coverage Code. Each endorsement (not only medical endorsements but also anesthesia, x-ray, lab, radiation therapy and others) is identified by number and explained in the Blue Shield Participating Physicians' Manual beginning on page XIII.

Q. Under the medical endorsement is there a plan that starts providing benefits for in-hospital medical care prior to the third or fourth day of the hospital confinement?

A. Approximately 75% of all Blue Shield subscribers have coverage for in-hospital care beginning prior to the fourth day of hospitalization. Only 25% have Standard Blue Shield with the fourth day medical endorsement. As recently as 1967 the number of Blue Shield subscribers having Standard Blue Shield was as high as 45%, and it has been largely due to the efforts of our enrollment staff that this percentage has been reduced to its present low. We will continue to make available higher levels of benefits and an increased effort will be made to upgrade the coverage of those few subscribers having Standard Blue Shield.

Q. Will the medical endorsement provide benefits for more in-hospital care to more than one physician (i.e., my physician cares for the patient from the first through the fifteenth day and another physician cares for the patient from the sixteenth through the thirtieth day of hospitalization)?

A. Yes. Each physician should file for that time in which he actually treated the patient. Medical endorsements will not provide benefits to two physicians for concurrent in-hospital medical care.



Geigy



Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.



One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C

For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6225

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

JANUARY

15 Methodist Evangelical Hospital, Fourth Annual Postgraduate Day Symposium, "Clinical Disturbances in Electrolyte and Acid Base Metabolism," Louisville

FEBRUARY

8 Fifth Oral Cancer Symposium, University of Louisville, Rankin Amphitheatre, General Hosital, Louisville

24-26 Kentucky Chapter, American College of Surgeons Sectional Meeting, Brown Hotel, Louisville

MARCH

26-27 KMA INTERIM MEETING, "The Challenge We Face in 1969," Continental Inn, Lexington

APRIL

29-May 2 "Current Concepts in Bone and Joint Disease," Symposium, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

JANUARY

15-16 Cleveland Clinic Educational Foundation Postgraduate Course, "Surgical Problems of the Liver, Biliary System, Pancreas and Spleen," Cleveland, Ohio

20-21 Cleveland Clinic Educational Foundation Postgraduate Course, "Cardiovascular and Renal Clinical Pharmacology," Cleveland, Ohio

20-Feb. 28 Six-Week Seminar, "Educational Science for Medical Teachers," Division of Regional Medical Programs. Dept. of HEW, University of Illinois College of Medicine, Chicago, Ill.

22 University of Cincinnati College of Medicine Symposium, "Man and the Value of Life," Cincinnati, Ohio

22-24 Lakeland Graduate Medical Assembly, "Frontiers of Medicine 1969," Cypress Gardens Sheraton Motor Inn, Cypress Gardens, Fla.

FEBRUARY

5-6 Postgraduate Continuation Course, "General Practice," Cleveland Clinic Educational Foundation, Cleveland, Ohio

12-13 Postgraduate Continuation Course, "Controversies in Angiography," Cleveland Clinic Educational Foundation, Cleveland, Ohio

MARCH

13-15 American Electroencephalographic Society Course in "Current Problems in Electroencephalography: Advances Toward Their Solution," Houston, Texas

19 "Man and His Urban Environment" Colloquium, Losantiville Room, University of Cincinnati Tangeman Center, Cincinnati, Ohio

21-22 Twenty-second National Conference on Rural Health, American Medical Association, Philadelphia Marriott Motor Hotel, Philadelphia, Pa.

25-28 Center for the Study of Medical Education Workshop, "Instructional Skills for the Medical Teacher", University of Illinois College of Medicine, Chicago, Ill.

28-29 Third National Congress on "The Socio-Economics of Health Care," American Medical Association, Palmer House, Chicago, Ill.

TWO INTERNISTS—Board Eligible or Certified, wanted by multi-specialty group in Central Texas Associated with 100-bed hospital; $20-$24,000 annual salary; early partnership; no investment. Write G. H. Wahle, Jr., M. D. King's Daughters Clinic, Temple, Texas, or call collect 817 778-5501.

PUBLIC HEALTH PAGE

Infectious Syphilis Outbreak in Kentucky†

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

IT IS important that cooperation exist between practicing physicians and health departments in the control and eradication of syphilis. There are many specific examples of how this cooperation can result in effectively reducing the incidence of syphilis; however, the most significant result occurs when prompt reporting of an infectious case leads to the diagnosis and treatment of additional infectious cases.

Depicted and described below is an outbreak of infectious syphilis that has recently been investigated in Southwestern Kentucky. Thanks to a private physician who diagnosed a case of primary syphilis and promptly reported the case to the health department, trained field epidemiologists were able to bring 11 additional infectious or recently infectious cases to medical examinations and treatment.

A total of 50 persons were involved in this outbreak and their ages range from 14-28. Only infected persons are shown on the chart.

Patient A: Initial case, primary syphilis, diagnosed and reported by a private physician. This 19-year-old female named one sex contact—Patient B.

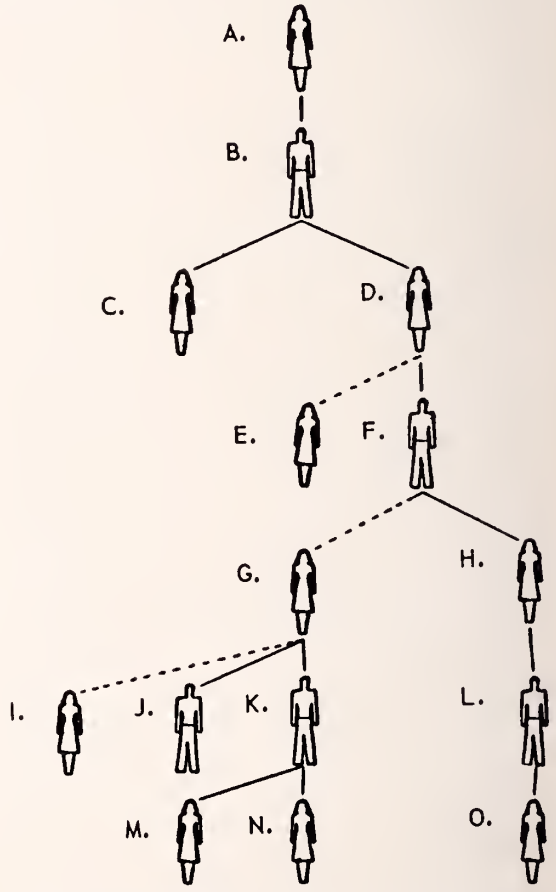
Patient D: Diagnosed secondary. Contracted her infection from Patient B. She is a housewife, expecting her third child.

Patient E: Diagnosed secondary. Was not named as sex contact, but brought to examination because of an alert local health department nurse who recognized signs and symptoms.

Patient F: Diagnosed primary. Husband of Patient D. Also spread from Patient D. This 21-year-old male was very active sexually. Provided additional information on other persons involved.

Patient G: Diagnosed secondary. Was not named as sex contact but as a friend of a named sex contact. She lived at home with her parents. She named six sex partners, two of whom were infected.

Patient H: Diagnosed secondary. This 19-year-old female had two illegitimate children. She named nine sex partners involving four counties in Kentucky and three different states.



Patient I: Diagnosed primary. Not named as sex contact but found at home of Patient J.

Patient J: Diagnosed primary. This 20-year-old male was diagnosed as having primary syphilis by a private physician in April 1968 but not reported. Consequently, he became reinfected in August 1968. Results: source of five needless infections.

Patient K: Diagnosed early latent. Was located and examined in Florida. He named nine sex partners in Florida, Tennessee and Kentucky.

Patient L: Diagnosed secondary. Very promiscuous, with both heterosexual and homosexual sex contacts. He was named as a sex contact in May 1968, was

†*This article was prepared by The Office of the Venereal Disease Program, Division of Epidemiology, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky*

examined but not prophylactically treated. Results: Two unnecessary infections.

Patient M: Diagnosed early latent syphilis. Based on incomplete epidemiological information, this patient, who was located and treated in Tennessee, is believed to be the probable *source* of the infections that occurred in Kentucky.

Patient N: Diagnosed primary syphilis by a Kentucky physician but was treated in Tennessee. This 18-year-old female, who attends high school, was a spread case from Patient K. She named three sex contacts in three different states.

While the above outbreak is small in comparison to others that have occurred in the state, it is presented on this page because it adequately demonstrates the need for constant statewide syphilis surveillance. It also points out the urgent need for prompt case reporting by private physicians, alert local health department personnel, confidential epidemiologic follow-up, and the administration of epidemiologic treatment to sex contacts found to be clinically and serologically negative.

The Venereal Disease Program of the Kentucky Department of Health is staffed with skilled field epidemiologists who are thoroughly trained and experienced in syphilis epidemiological procedures as well as darkfield microscopy techniques. Physicians can utilize these services by contacting their local health department or the State Department of Health. The eradication of syphilis as a public health problem will depend on a cooperative effort between public and private medicine.





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

Medical Economics says:

GENERAL LEASING'S PLAN IS

"The Winning Way"

TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ Leasing better than buying
- ★ No capital investment
- ★ Dependable car at all times
- ★ Certain tax advantages
- ★ Call us for particulars

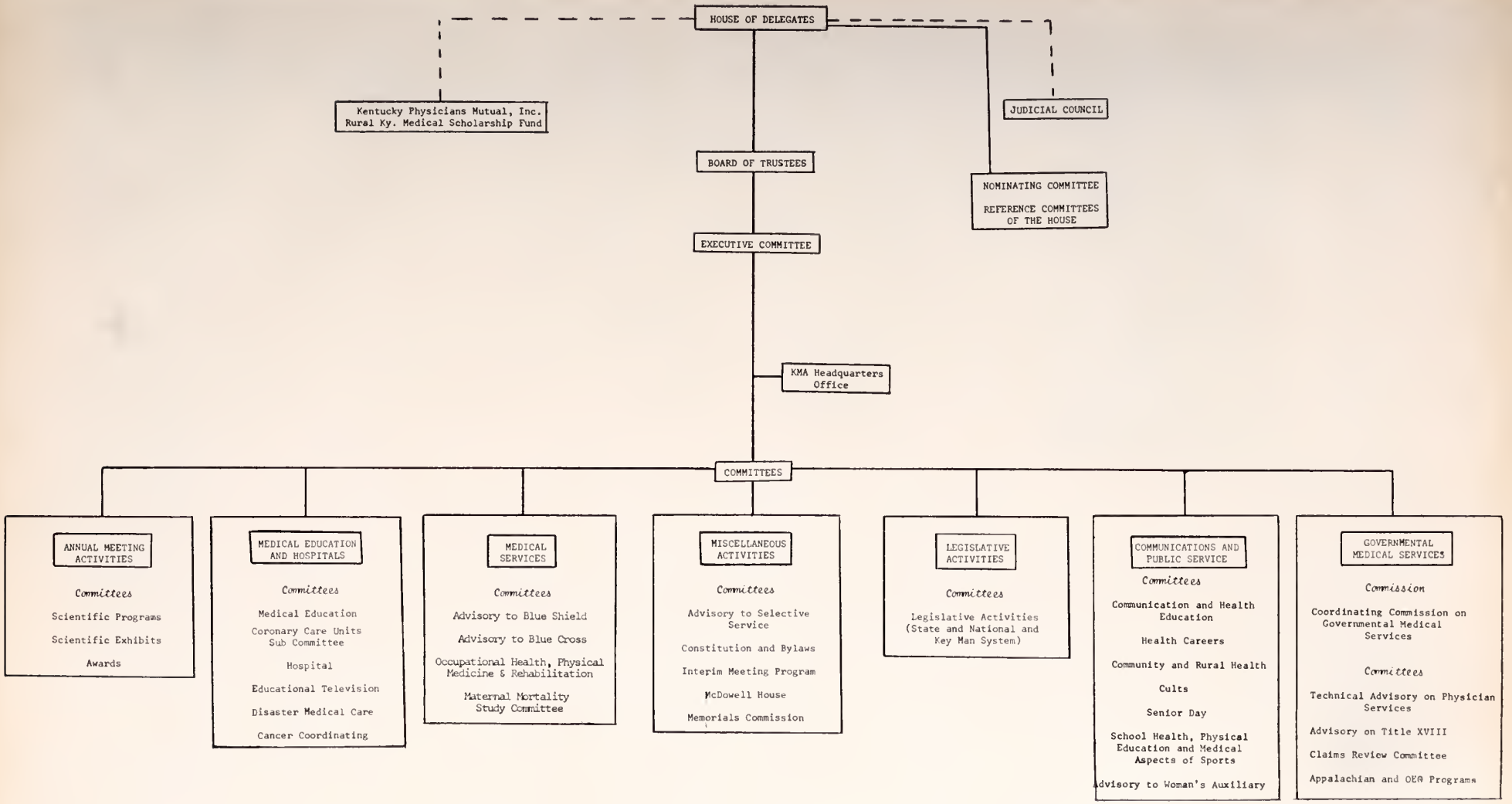
LEASE
Medical or Surgical
EQUIPMENT

- ★ A plan for young doctors
- ★ Medical and Surgical equipment
- ★ Complete office furnishings
- ★ Enlarging facilities
- ★ Call us for full details

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207



KMA Organization Chart–Revised September 25, 1968

AD HOC COMMITTEES

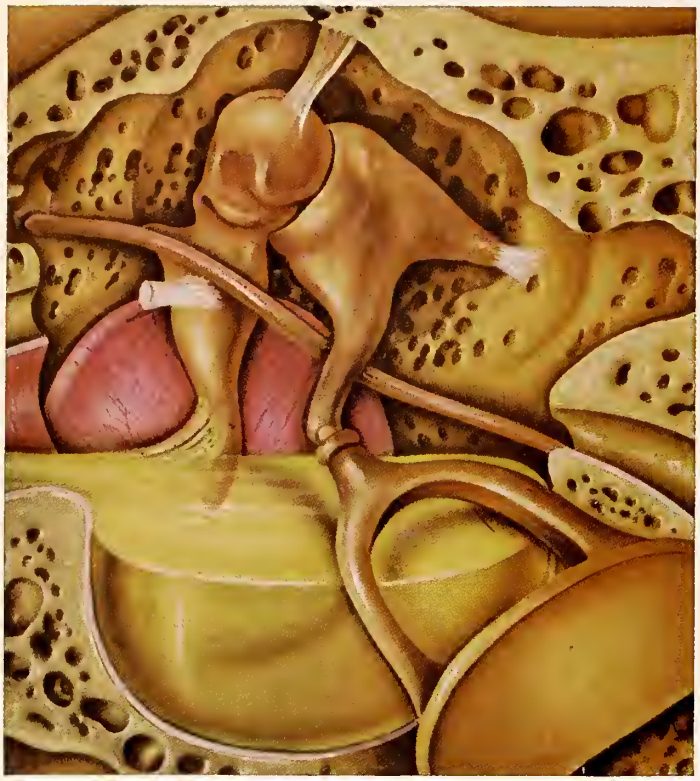
Comprehensive Health Planning
Plans and Development
Improved Community Health
KMA-KNA Joint Advisory
Medicine and Religion Representative to AMA

See next page for prescribing inform



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, t most common invaders. In otitis media, where i is difficult to isolate the causative organism, thi coverage may be important. However, some stra may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged acti permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enteroco pruritus ani. Skin—maculopapular and erythematous rashes; a case of exfoliative dermatitis has been reported. Photosensiti onycholysis and discoloration of the nails (rare). Kidney—rise in B apparently dose-related. Transient increase in urinary output, so times accompanied by thirst (rare). Hypersensitivity reactions—u caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (low-brown) in children of mothers given this drug during the latter of pregnancy, and in children given the drug during the neonatal p od, infancy and early childhood. Enamel hypoplasia has been see a few children. If adverse reaction or idiosyncrasy occurs, disconti medication and institute appropriate therapy. Demethylchlorte cycline may form a stable calcium complex in any bone-forming tis with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sho be given 1 hour before or 2 hours after meals, since absorptio impaired by the concomitant administration of high calcium cont drugs, foods and some dairy products. Treatment of streptoco infections should continue for 10 days, even though symptoms h subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, mg, 150 mg and 75 mg of demethylchlorte cycline HCl.

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis – or to help prevent the acute condition from becoming chronic.

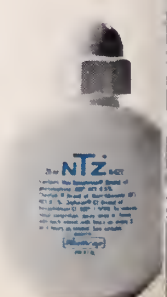
Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

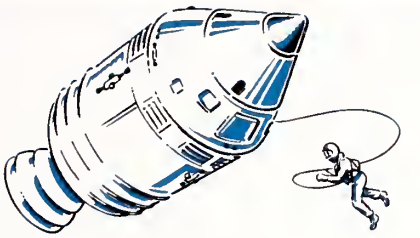
Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



The two-stage power of the pink pill for U.R.I. symptoms is nothing to be sneezed at.

e immediate and continuous-release
tions built into each Novahistine
nglet can give most of your patients
ompt and long-lasting relief from
mptoms of upper respiratory infection,
luding fever, aches and pains.
t only does Novahistine Singlet
ovide a vasoconstrictor-antihistamine
mulation to reduce congestion and
lp restore normal ciliary activity; it
o contains an antipyretic-analgesic
mpound to relieve the fever, aches
d pains that so frequently accompany upper respiratory infections.
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Pitman-Moore Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134 **Additional information available to physicians upon request.**

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 JANUARY, 1969 No. 1

Tuberculosis Eradication ?

N. A. SALIBA, M.D.*
Louisville, Kentucky

Present trends in tuberculosis management and control are discussed and a tuberculosis program outlined. Most cases in Kentucky are first reported in moderate or far advanced disease, pointing to need for a wider application of available tools.

Acknowledgment

I wish to acknowledge the expert assistance of Mrs. M. Eckhardt and Mr. J. Floyd.

THE eradication of tuberculosis has been predicted on many occasions in the past, and yet this disease today is still very prevalent in many parts of the world and in certain areas of the U. S.[1,2] In the real sense of the word, eradication in any part of the world is probably a myth more than reality, at least for the foreseeable future. Much has been achieved in the treatment and control of tuberculosis in this country and throughout the world; much remains to be done.[3,4] Even in these United States complete control is something one looks forward to in the future.

At the local level, Kentucky occupies the second highest position as regards case rate, and the case rate for 1966 was still about the same as for 1959 (40 per 100,000). This, as in the case of other states, is substantially higher than the national average. Therefore some states have more of a problem to cope with than others; within individual states there are pockets of remarkable persistence of this "ancient disease". Similarly different countries face different problems regarding tuberculosis, the more underdeveloped nations of Asia, South America, etc., still dealing with an enormous tuberculosis morbidity and mortality. By and large, a major tuberculosis incidence in any part of the world is one that should interest all medical agencies.

Changing Times

We have the means to achieve a marked improvement in this situation if the tools we already possess are applied wisely. Tuberculosis has reached a phase where the overall hospital program is gradually playing a smaller role, with greater emphasis being placed on the outpatient clinics and home environment. In this sense then, the health departments and field clinics should play a major role in the supervision of patients. The family physician has in the past had a minor role in the treatment and control of tuberculosis but here again with changing concepts, the family physician should now play a much larger and increasingly important role. The proper evaluation and supervision of contacts of an active case, regular tuberculin testing as a part of office practice, chemoprophylaxis — these are areas in which the general practitioner could participate and thus help the overall program of tuberculosis control[5]. The chest clinics could be de-

*Director, District Two State Tuberculosis Hospital, and assistant clinical professor of medicine, University of Louisville School of Medicine

veloped as regional centers for the supervision of out-patient treatment, follow-up care and diagnostic services in full cooperation with local health departments and medical societies. Proper coordination is of utmost importance.

Tuberculosis Control Program

This subject is approached from different angles in different areas, influenced mainly by local factors. An adequate program would include most or all of the following:

1. Permanent out-patient follow-up of all known cases. Not uncommonly patients have been dismissed from clinics after a number of years. This practice is not recommended because it at times gives rise to a degree of complacency in patients who then fail to report an early change in symptoms and thus fail to detect a possible early breakdown in their disease. A follow-up evaluation should therefore be maintained for the rest of the patient's life. This would imply an increase in home visits by nurses, writing to patients when they fail to keep a clinic appointment, or the transfer of records to health departments whenever patients change their residence. Here again, close cooperation with family physicians is essential.

2. Adequate and appropriate treatment of all active cases. This implies a sufficient combination of drugs in the proper dosage, especially the selection of drugs to which the bacilli are susceptible, and which the patient tolerates well.[6,7]

3. Examination of all contacts. This should include household members as well as other periodic visitors to the household such as relatives. Other contacts such as people in connection wtih one's occupation, school bus drivers, baby sitters, food handlers, etc. would be included. Here adequate follow-up is also indicated.

4. Regular skin testing in schools. This is an effort that should be aimed at the entire school population, including teachers and employees, and should ideally be carried out at least every other year. Appropriate permanent records should be kept such as number of positive reactors and number of skin test converters, classified by grade, by school and by county. Thus a reasonable estimate of the size of the problem can be available at each survey. All doubtful reactions should be repeated, great care being taken regarding technique.

5. Increasing scope of chemoprophylaxis. Groups of positive reactors in the school population, if there is no evidence of clinical disease, will be considered for prophylactic treatment.[8] The drug presently used is Isoniazid usually in a dosage of 300 mg. per day while the children maintain their normal activities. It is usually given for a period of one - two years. All those with a skin reaction of 15 to 20 mm. induration or over should be considered for chemoprophylaxis; also those with a positive reaction of less than 15 mm. and with a strong family history of tuberculosis or a close contact history; those recently converted to positive within a period of six to twelve months. Some will also include those children with a negative tuberculin reaction in a household with an active case of tuberculosis. This is somewhat debatable because in certain areas others might prefer to use BCG vaccination on an individualized basis; in most cases, however, such children are supervised with repeated tuberculin testing and the active cases treated. Chemoprophylaxis is also indicated in old treated cases of tuberculosis who may have complicating diabetes that is unstable, inactive cases of tuberculosis during pregnancy, or those who require corticosteriods. Patients who have abnormal x-ray findings apparently healed, but who never had a positive diagnosis or specific treatment and where previous tuberculosis is a likely diagnosis could be considered for preventative measures using single or combined drug regimens. All patients who need prolonged corticosteroid treatment and whose tuberculin reaction is positive should also be placed on Isoniazid. Other groups would be those with anthracosilicosis and a positive tuberculin reaction, and patients who have surgery for peptic ulcer. Other clinical entities may come under the realm of chemoprophylaxis as we learn of the benefits of such a program.

6. A re-evaluation of BCG for highly selected groups. In many parts of the world BCG is used as a major part of tuberculosis control. In this country there is general agreement that mass BCG vaccination should have no consideration, but some feel that it could

still be indicated for properly selected small groups in areas where tuberculosis remains highly prevalent, in selected households, for groups of personnel with a high degree of exposure to tuberculosis, and for those going overseas in a high prevalence area. Under such conditions BCG might possibly still play a useful role together with chemoprophylaxis and other measures to insure better tuberculosis control.

The Problem in Kentucky

Much remains to be done in Kentucky. The state at present ranks second highest in the nation as regards case rate. Both the case and death rates are above the national average although in the past several years the trend has been downward. (Figure 1) There are undoubtedly many problems in Kentucky but probably this situation in tuberculosis is related to socioeconomics. The lack of a unified medical agency that is responsible for an effective program also plays a role and the recruiting of adequately trained professional personnel has usually been difficult. The family physician, too, may have much to contribute towards the alleviation of the tuberculosis problem in this state.

At present over 50% of *newly* diagnosed cases of tuberculosis are seen already in a moderate or far advanced stage of the disease; some of these are admitted in a critical status. This would indicate that there is an education gap or a neglect of symptomatology to such an extent that these people may be ill many months before actually receiving a diagnosis.

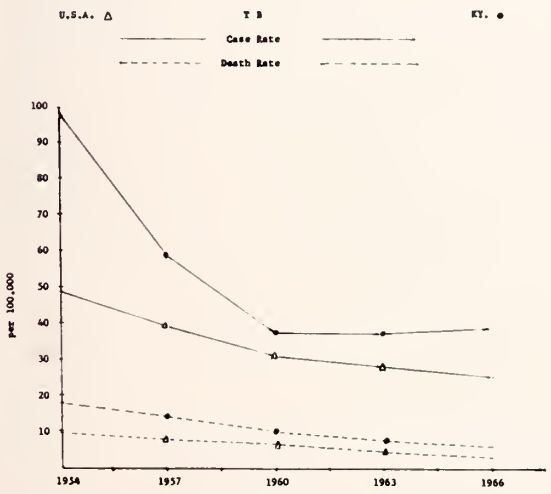


FIGURE 1



FIGURE 2A



FIGURE 2B

FIGURE 2A shows the extremely poor nutritional status of the patient on admission on 3-21-68. The extensive bilateral cavitary tuberculosis on his chest x-ray is shown in FIGURE 2B.

The danger lies in the risk of further progression of the disease in the patients themselves and the possible transmission of the infection to others when these patients are more than likely highly contagious, before the initiation of treatment.

The number of admissions to the tuberculosis hospitals in the last five years has increased, thus suggesting that new cases are being brought under proper evaluation and treatment. The duration of hospitalization is



FIGURE 3. A 24 year old female admitted 8-3-65 with far advanced pulmonary tuberculosis. Chest x-ray showed multiple cavities in the right lung and a large cavity in the left apex, besides disseminated nodular and infiltrative lesions bilaterally. Her sputum converted in the third month of treatment and she subsequently continued with outpatient chemotherapy.



FIGURE 4. This 13 year old girl was admitted in February, 1966. She had an essentially destroyed left lung, with a spread into her right upper lobe mainly. In keeping with her clinical improvement her sputum converted in the second month of treatment. A left pneumonectomy was still necessary because of the irreversible destructive process.

gradually decreasing, and there is room for further improvement in this direction. The number of out-patient visits throughout the state field clinics is rapidly increasing. The current figure is close to 40,000 per year. This suggests that greater supervision is being maintained on a larger number of patients. In spite of this, however, one not infrequently sees old cases of tuberculosis that have received inadequate follow-up and have thus resulted in massive extension of the disease when relapse is first discovered.

The following is an example of such a patient who was diagnosed at a late stage. A 64 year old white male was recently admitted to our hospital on 3-21-68. His condition was extremely critical and he expired after two days of hospitalization. Figure 2 shows the extent of the man's cachectic condition and the severe bilateral cavitary pulmonary disease on his chest x-ray. His hemoglobin was 11.4 grams, hematocrit 34 volumes percent, WBC 5000, with polys 76, stabs 7, lymphs 16, monos 1. The serum sodium was 128 meq/l, potassium 4.2 meq/l, chloride 88 meq/l, calcium 5.2 mgs. %, BUN 20 mgs. %. The blood pH was 7.37, pCO_2 45 mm. Hg., total protein 6.0 gm. with albumin 3.0 and globulin 3.0. Liver function studies were within normal limits. The patient was treated with intravenous fluids and a blood transfusion, antimycobacterial drugs and other supportive measures with no improvement. At autopsy there was "evidence of extensive cavitary disease with caseation necrosis in both lungs, fibrosis and emphysema and superimposed pneumonia. Tissue stains were positive for acid fast bacilli".

Figures 3 to 8 are some further examples of patients that are fairly regularly admitted to our hospital and fit the above descriptions. These are patients with an initial diagnosis of tuberculosis when the disease has already extensively involved both lungs in most cases with large cavities. It is unfortunate that even young people can reach such a state without previous diagnosis in spite of all available knowledge and resources. In this example (Figure 4) such a delay resulted in a left pneumonectomy in a 13 year old girl. This could well have been avoided with an earlier diagnosis.

Discussion

The concepts of tuberculosis control have certainly changed, but one needs to see more general agreement on some of the outlines by the committee on chest x-ray.[9] That is, that

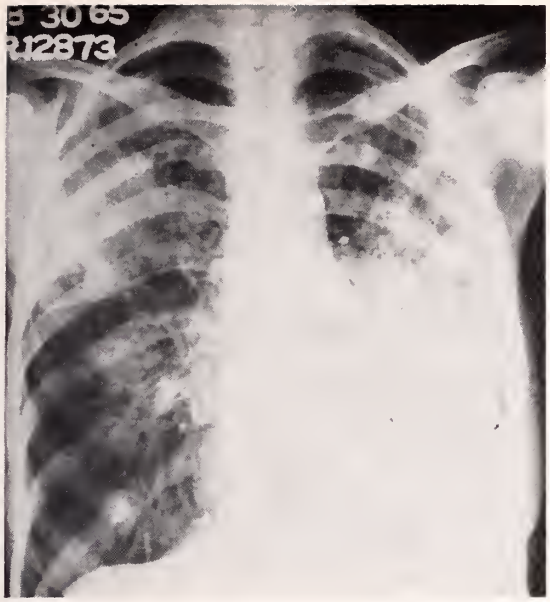


FIGURE 5. A 34 year old female was admitted in August, 1965 with extensive tuberculous pneumonia on the left and a spread to the right lung. Her sputum converted during the second month of treatment and there was marked clinical and radiologic improvement.

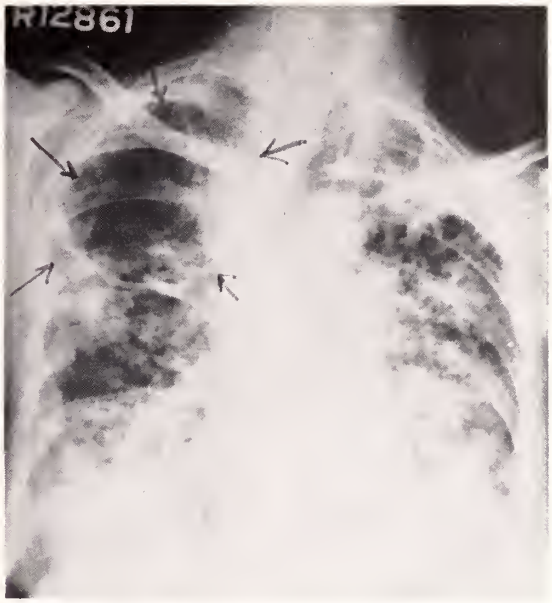


FIGURE 6. This 47 year old female was admitted in August, 1965 with very extensive bilateral tuberculous disease on her chest x-ray. Multiple cavities were present, including an excavated right upper lobe. Her sputum converted during the third month of treatment, with marked clinical and moderate radiologic improvement.

"overoptimism and complacency could result in a resurgence of tuberculosis from its present state, as happened in the case of gonorrhea and syphilis"; also the fact that tuberculosis may be expected to continue in one outbreak after another if the tools we now have are not properly used.

These changing concepts should imply changing attitudes on the part of physicians. For example it has been shown by the Madras studies that under certain conditions treatment of active tuberculosis in the home environment can yield comparable results to hospital treatment. This is obviously not recommended for areas where hospital facilities are readily available, but in some instances it may become necessary. One should at least aim for a rapid reduction in the number of weeks or months that most patients need to remain in the hospital. Mitchell[6] suggests that rather than keeping patients longer in hospital to supervise their drug intake, a more logical approach would be a vastly increased visiting nurse service for out-patient management. He further emphasizes that unless intensified efforts are directed to the field of tuberculosis control, further major improvements from the present status cannot be expected.

Ideally all newly diagnosed or suspect cases should be hospitalized initially for intensive bacteriologic and other studies[10], a trial of chemotherapy, followed in many instances by an early discharge as soon as there is evidence of beginning sputum conversion.

It was suggested several years ago that with increasing knowledge of the mechanism and beneficial effects of chemotherapy, bed rest was no longer indicated for the majority of cases and might even be considered antagonistic to the optimal action of antimicrobial drugs[11]. A clinical and laboratory study revealed no deleterious effect of physical activity on the course of the patient's recovery. This holds true even today in that prolonged bed rest is only occasionally indicated.

A similar study with a different goal showed that mild cases of tuberculosis treated with chemotherapy at work did as well as those treated with chemotherapy and bedrest.[12] This approach was not to be taken lightly, because extreme patient cooperation and supervision and a non-infectious status would be mandatory.

In an interesting paper[13] Lester points out that although historically tuberculosis has been related to socioeconomic pathology, and its residual concentrations will persist in those

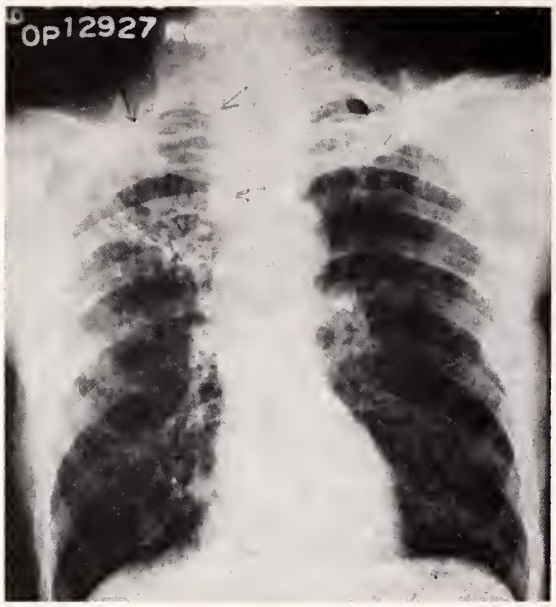


FIGURE 7



FIGURE 8

FIGURES 7 and 8 are examples of two patients with far advanced pulmonary tuberculosis who expired within a short time of hospitalization. The patient in FIGURE 7 had complicating renal tuberculosis.

areas of overcrowding and poverty, he shows that these conditions are not unique to large cities. For example, they can also be found in rural areas such as Appalachia. However, because of the larger concentration of persons in urban centers, he felt that the majority of new cases in the future will come from such centers. He predicted that as the morbidity and mortality continued to decline, so will the need for large clinical and hospital facilities. The need for accurate diagnosis and proper treatment would persist and become more urgent, because if this is not properly done failures would ensue. This danger would become increasingly realistic in the future, for if such cases are not seen by experienced physicians, unfortunate and otherwise avoidable errors will result. Drug resistant tuberculosis can present special difficulties.[14,15]

Much can be achieved in the treatment of patients, even those with massive disease as have been presented here. (Figures 9-10). One needs to emphasize the fact that an earlier diagnosis and earlier and adequate treatment would insure optimum results with fewer sequelae. It is estimated that between 96 and 98 percent of newly diagnosed cases could be rendered noninfectious with a variable degree of radiological improvement within a few months of the onset of treatment. An earlier diagnosis would mean the prevention of much disability. Such disability results in prolonged hospital and medical care for many of these patients; many of them become incapacitated for most occupations.

Finally, one must conclude that a review of the above suggests that there is no reason for Kentucky to be lagging at the bottom of the 50 states in the field of tuberculosis control. The school skin testing program should be expanded rapidly and uniformly to include all grades in all schools over the entire state. For this to be meaningful a thorough evaluation

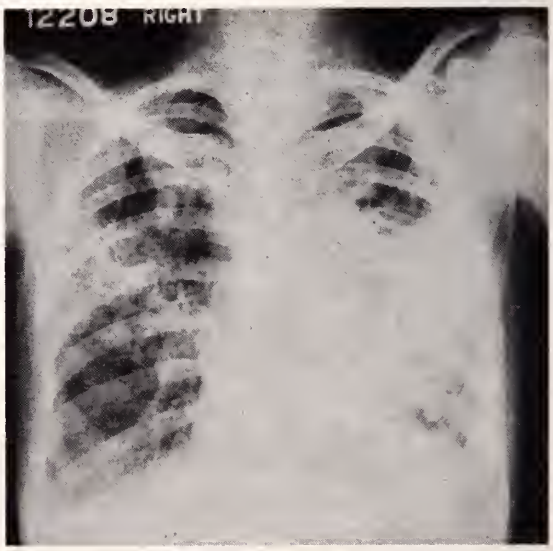


FIGURE 9. An example of a patient with very extensive bilateral pulmonary tuberculosis.

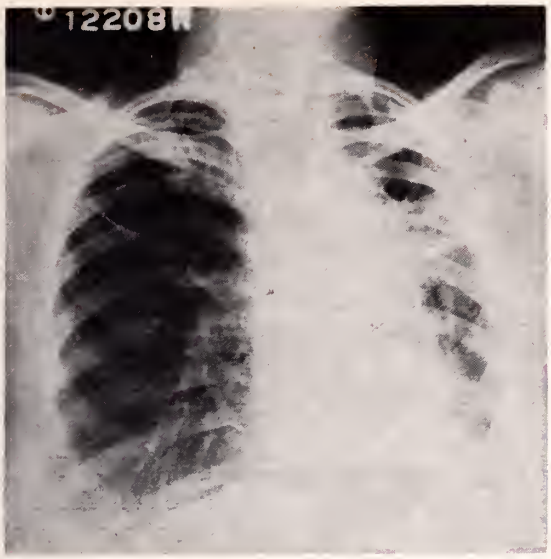


FIGURE 9A shows a marked radiologic improvement during treatment, although the left upper lobe cavity persisted. Sputum converted during the second month of treatment.



FIGURE 10 shows another far advanced case of tuberculosis with bilateral cavitation.

of all reactors and their contacts is of paramount importance as is the adequate recording of data. All available resources should be applied to such a program in this state without delay.

It is indeed a more logical approach and a more economic undertaking to find these patients at the stage of infection or the early phases of the disease and see that they receive the appropriate care they need at the right



FIGURE 10A shows marked bilateral improvement during treatment with re-expansion of the partially collapsed right upper lobe and contraction of the large cavity in the left upper lobe. Sputum converted during the fourth month of treatment.

time. This would be extremely beneficial both to the patients themselves and to the community as the cure rate can be high indeed. This would result in a marked advance towards tuberculosis control, and as some progress is already being made, we need to realize an overall intensification of our efforts.

Bibliography

1. U. S. Department of Health, Education and Welfare, "Reported Tuberculosis Data", 1964.
2. Saliba, A., "Tuberculosis Today", *Brit. J. Dis. Chest*, 54, 22, 1960.
3. Russell, W. F., Kass, I., Heaton, A. D., Dressler, S. H. and Middlebrook, G., "Combined Drug Treatment of Tuberculosis", *J. Clin. Investigation*, 38, 1349, 1959.
4. Corpe, R. F., and Blalock, F. A., "Alternating Regimens of Streptomycin-Pyrazinamide, Isoniazid-Paraminosalicylic Acid at Battey State Hospital", *Am. Rev. Resp. Dis.*, 90, 262, 1964.
5. Committee on Chemoprophylaxis, "Chemoprophylaxis for the Prevention of Tuberculosis", *Am. Rev. Resp. Dis.*, 96, 1967.
6. Mitchell, R. S., "Control of Tuberculosis", *New England J. Med.*, 276, 842, 1967.
7. Saliba, A., and Beatty, O. A., "Choice of Initial Chemotherapy Regimen in Pulmonary Tuberculosis", *Dis. Chest*, 40, 259, 1961.
8. Curry, F. J., "Prophylactic Effect of Isoniazid in Young Tuberculin Reactors", *New England J. Med.*, 277, 562, 1967.
9. Committee on Chest X-ray, "The Sleeping Dragon-TB", *Dis. Chest*, 42, 657, 1962.
10. Myers, J. A., "Eighty Years After the First Glimpse of the Tubercle Bacillus", *Dis. Chest*, 51, 500, 1967.
11. Hirsch, J. G., Schaedler, R. W., Pierce, C. H., and MacLean Smith, I., "A Study Comparing the effects of bed rest and physical activity on recovery from Pulmonary Tuberculosis", *Am. Rev. Resp. Dis.*, 75, 359, 1957.
12. Research Committee of the Tuberculosis Society of Scotland, "The Treatment of Pulmonary Tuberculosis at Work: A Controlled Trial", *Tubercle*, 41, 161, 1960.
13. Lester, W., "Tuberculosis: An Urban Problem", *Ann. Int. Med.*, 68, 947, 1968.
14. Saliba, A., and Beatty, O. A., "Retreatment of Tuberculous Patients", *J. Southern Med. Assn.*, 54, 10, 1961.
15. Fischer, D. A., Lester, W., Dye, W. E., and Moulding, T. S., "Retreatment of Patients with Isoniazid-Resistant Tuberculosis", *Am. Rev. Resp. Dis.*, 97, 392, 1968.

Treatment of Non-Tuberculous Empyema†

PORTER MAYO, M.D. AND RICHARD B. MCELVEIN, M.D.

Lexington, Kentucky

Early thoracotomy and decortication in the treatment of non-tuberculous empyema offer prompt relief of toxicity and excellent long-term results.

NON-TUBERCULOUS empyema continues to occur despite wide-spread use of antibiotics. Purulent content in the pleural space usually results from preceding lung infections. Other causes include chest injury, foreign bodies, bronchiectasis, esophageal perforation and sub-diaphragmatic disease. Diagnosis may be made without difficulty. Symptoms include chills, fever, cough, chest pain, dyspnea and toxicity. Physical findings include decreased breath sounds throughout the affected hemithorax and marked impairment of expansion of the diseased side. Patients frequently are anemic. Chest x-ray shows clouding or complete opacification of a portion of the involved lung and pleural space. Intrapleural and/or intrapulmonary fluid levels may be present.

Theoretically, all cases of empyema could be diagnosed in the acute exudative phase, when appropriate therapy could in a large number of patients, prevent progression of the fibrinopurulent phase and, ultimately, to the organizing phase. Several methods of treatment of empyema are available. Two most common means include thoracentesis and tube drainage which, all too often, are distressingly inadequate. We have advocated an early thoracotomy with evacuation of all purulent content, combined with decortication of the fibrinous peel and complete lung re-expansion as the primary drainage procedure. Each patient in this report had a heavy purulent content in the pleural space and a thick fibrinous peel enveloping part or all of the lung. This method does not pertain to amber pleural fluid collections subsequent to pulmonary infections which can easily be treated by thoracentesis and/or tube drainage.

During the past 12 years, we have performed 44 early open thoracotomies as the initial procedure in the treatment of nontuberculous empyema. Patients so treated have shown prompt loss of toxicity and restoration of normal pulmonary function. When a decision has been made for drainage, it should be one which completely eliminates all purulent content with restoration of a normally functioning lung. The disease not only is brought under control—it is eliminated.

Bacteria most often responsible for non-tuberculous empyema are Staphylococcus aureus and Hemolytic Streptococcus. Staphylococcus aureus predominates in children and Hemolytic Streptococcus in adults. Type of infection does not affect the surgical approach or outcome of empyema.

Operative Procedure

We open the chest by posterolateral incision, enter the pleural space through the bed or interspace of the fifth or sixth rib, and evacuate all intrapleural debris. We next remove the thick fibrinous peel from the lung, chest wall, mediastinum, pericardium, and diaphragm. The trapped lung usually shows minimal damage. Fifteen to 20 percent of our patients show a fistulous communication and/or necrotic disease representing a ruptured abscess. We excise the necrotic material and close small bronchial air leaks with catgut sutures. Complete mobility of the motionless diaphragm can be restored by removing the surface peel and the same is true for the mediastinum and chest cage. The expanded lung and return of mobility to the diaphragm and chest cage restore normal pulmonary function. Intercostal tubes are inserted and the chest closed with non-absorbable suture. Prompt drop in temperature, pulse rate, and respiratory rate occurs with an obvious loss of toxicity. We remove chest tubes within 48 to 72 hours and

†*Presented at the Kentucky Chapter, American College of Surgeons Meeting, April 5, 1968, Lexington, Ky.*

discharge most patients within one week, postoperatively.

Comment

In our series of 44 patients, the ratio of men to women has been seven to one. Twenty patients were under the age of 10. Age range of patients was from five months to 66 years.

Duration of symptoms varied from one to four weeks with seven other patients having had symptoms for more prolonged periods. There is no pre-set optimum time interval from onset of symptoms to surgery. Progress of the disease varies and a short period of symptoms does not necessarily indicate low-viscosity fluid which may be easily removed by needle or tube. We have been impressed by the extensive loculation, gelatinous consistency and marked fibrous reaction in patients having a short medical history. Stage of disease does not necessarily correspond to duration of symptoms. Rather than waiting a certain predetermined number of days or weeks, we surgically intervene and convert a toxic, febrille, dyspneic patient to good health.

An initial period should not be spent preparing patients for thoracotomy and decortication. Toxicity, fever, malaise, pain and other related symptoms are more rapidly brought under control by complete elimination of the empyema and lung re-expansion. Several children have been operated upon the day of admission and results have been far superior to those patients in which preoperative preparation delayed the essence of treatment, specifically, complete drainage. The patient is not just discharged but discharged well. Of equal importance, they stay well.

We are so convinced that this method of treatment provides the best management of patients having heavy fibrinopurulent empyema that we have stopped the use of antibiotics postoperatively. Rare exceptions include those patients having residual severe pneumonitis and/or other underlying lung disease. Patients in our group receiving no postoperative antibiotics have included those with mixed infection and also post-Staphylococci pneumonic empyema. These latter four patients were discharged an average of seven days postoperatively. They had the same temperature curve as other patients and a progressive decrease in the white blood cell count.

We have had no mortality and minimal complications. Three skin stitch abscesses and one minimal bronchopleural fistula occurred. The latter healed promptly. No patients have required secondary surgical procedures and no chest tubes have been re-introduced into the chest. There has been no recurrence of empyema.

Hesitancy in utilizing early thoracotomy and decortication has been due to the belief that empyema can be adequately treated in most instances by a medical regimen with the assistance of thoracentesis and/or variations of tube drainage; also, the commonly held erroneous view persists that such a major procedure in patients having toxic symptoms secondary to empyema may cause a fulminating crisis or at least aggravate an already seriously ill patient. To the contrary and now thoroughly documented, we believe the reluctance to more actively attack empyema in the fibrino-purulent and organizing stage denies the patient an opportunity to avoid prolonged hospitalization and the repugnant allies of tube drainage, namely pain, multiple dressings, increasing protein deficit, thoracic contracture, scoliosis and pulmonary function impairment. The odor of prolonged tube drainage often saps the patient's appetite. Tube thoracotomy, an unnecessary delaying procedure, is inadequate and ill-advised. Follow-up of our 44 patients over a period of 12 years allows one to emphasize the absence of mortality and the scarcity of complications.

Conclusions

Early thoracotomy and decortication for nontuberculous empyema has been performed in a series of 44 patients with prompt physiological response, short hospitalization, no mortality, minimal complications and excellent long term results.

Bibliography

1. Mayo, Porter: Review of Pulmonary Decortication in the Treatment of Non-Tuberculous Empyema. *International Congress on Diseases of Chest—A Summary*, p. 113, 1964.

2. Mayo, P., and McElvein, R. B.: Early Thoracotomy for Pyogenic Empyema. *Ann. Thorac. Surg.* 2:649, 1966.

3. Yeh, T. J., Hall, D., and Ellison, R. G.: Empyema Thoracis: A Review of 110 Cases. *Am. Rev. Resp. Dis.* 88:785, 1963.

4. Bryant, Lester R., Chicklo, James M., Crutcher, Richard, Danielson, Gordon K., Malette, William G., and Trinkle, J. Kent: Management of Thoracic Empyema. *The Journal of Thoracic and Cardiovascular Surgery*. 55:850, No. 6, June, 1968.

An Evaluation of the Therapeutic Efficacy of Intravenous Local Anesthetics

RONALD W. DUNBAR, M.D.* AND PETER P. BOSOMWORTH, M.D.**

Lexington, Kentucky

Local anesthetics have proven to be valuable therapeutic adjuncts when used intravenously. The purpose of this review will be to evaluate the indications and therapeutic effectiveness of intravenous local anesthetics in various medical situations.

IN RECENT years the intravenous use of local anesthetics has gained increasing acceptance in a wide variety of conditions. These include the production of analgesia, control of arrhythmias, suppression of reflexes such as coughing, prevention of succinylcholine induced fasciculations and muscle pains, controlling the convulsions of status-epilepticus, and as an adjunct to general anesthesia. Although these applications have been demonstrated, it is increasingly clear that indiscriminate and improper use of intravenous local anesthetics can lead to serious and conceivably tragic complications. The purpose of this review is to describe and evaluate the efficacy and hazards of intravenous administration of local anesthetics in several medical situations.

Anti-arrhythmic Effects of Local Anesthetics

Lidocaine is being used in increasing numbers of patients for the treatment of ventricular arrhythmias, both in and out of the operating room. The drug can terminate ventricular tachycardia, suppress multifocal ventricular extra-systoles, and suppress an impulse arising from an irritable focus in the ventricle. Harrison, Sprouse and Morrow in a study of the anti-arrhythmia properties of lidocaine and procaine amide have shown that the use of both compounds resulted in an increase in the stimulation threshold of the ventricle during diastole[1]. Neither drug caused a significant change in the duration of the absolute refractory period. Lidocaine in doses of 1 to 2 mg. per kilogram body weight produced no significant circulatory depression but every patient given procaine amide, 2 to 4 mg. per kilogram of body weight, evidenced a fall in arterial pressure and a decrease in the contractile force of the right ventricle. These physiologic observations and the clinical experiences with the use of lidocaine indicate that it is an effective anti-arrhythmic agent and it is preferable to procaine amide in the management of ventricular arrhythmias.

A single bolus of 1-2 mg. per kilogram of lidocaine will, in most instances, terminate ventricular tachycardia and abolish premature ventricular contractions. The duration of the anti-arrhythmic effect of a single bolus of lidocaine is relatively brief, being in most instances 10 to 20 minutes. This property of the drug makes it particularly suitable for use in surgical patients, since arrhythmias in the operative or postoperative period are usually precipitated by some acute stimulus which can be corrected. Lidocaine has been found useful in the course of cardiac catherization where a ventricular arrhythmia may be precipitated by the physical contact of the catheter with the ventricular wall. It has been used prophylactically when ventricular irritability was present before the cardiac catherization.

Chronic administration of lidocaine to conscious patients has been recently recommended for the prevention of arrhythmias occurring subsequent to myocardial infarction[2,3]. Under these circumstances toxic effects are most frequently observed. Three major side effects during chronic intravenous administration are hypotension, central nervous system depression and convulsions. It has been shown the toxic level is approximately 5 μ. per ml. of lidocaine in the plasma in the conscious patient while anesthesia increases the tolerance to 10

*Assistant professor, department of anesthesiology, University of Kentucky Medical Center, Lexington
**Professor and chairman, department of anesthesiology, University of Kentucky Medical Center, Lexington

μ. ml[4,5]. It appears necessary to achieve a blood concentration of 2 to 4 μ. per ml. in order to prevent or reverse arrhythmias secondary to myocardial infarction, thus the recommended intravenous infusion rate is 20 to 50 μ. per kilogram of body weight per minute. The arterial pressure and EKG should be monitored during lidocaine administration. In the presence of heart block with a slow heart rate the drug should rarely be used and then only with extreme caution since lidocaine may intensify the block.

Intravenous Regional Anesthesia

In April of 1908 August Bier reported on a series of 30 patients anesthetized with the intravenous administration of procaine[6]. The local anesthetic was introduced into the vein and confined to a limited area of the extremity with the application of two tourniquets, one above and one below the surgical site. Bier reported that 60 to 80 ml. of procaine, 0.25 to 0.5% was required for knee surgery, 40 to 50 ml. for surgery of the elbow and 25 ml. for surgery of the extremity in children. The procedure was abandoned in 1910 with the report of a fatal complication. In 1963 Holmes reintroduced the technique and its use has since become widespread due to the fact that it is easy to administer, highly effective and most important, free of toxic side reactions when properly handled[7].

In recent years surgery of the upper extremity has been frequently managed by supraclavicular brachial plexus block and axillary arm block, while subarachnoid and epidural blocks have been recommended for lower extremity procedures. These methods require frequent application by the anesthesiologist if he is to maintain a high success rate. Furthermore, the complications of these blocks which include pneumothorax, spinal headache, hypotension, systemic absorption of large quantities of the drug and possible total spinal anesthesia are all potentially serious ones.

Intravenous regional anesthesia is quickly and easily administered and requires little practice to obtain good results. However, the safety of the technique has been questioned[8,9]. Therefore, some comments on toxicity and effectiveness are in order. There are many reports on this method of anesthesia with most investigators indicating successful results. Only one adverse reaction has been reported if a dosage schedule based on body weight is used. The most commonly employed drug is 0.5% lidocaine administered in a dose of 3 mg. per kilogram body weight. Fifteen minutes has been arbitrarily set as the minimum time prior to tourniquet release to avoid serious reactions due to high blood anesthetic concentrations. A pneumatic tourniquet should be used to prevent gradual deflation frequently seen with a standard blood pressure apparatus.

In a previous study Dunbar and Mazze reported average peak plasma lidocaine concentrations after intravenous regional anesthesia as 1.5 μ. per ml. with no single value greater than 2.7 μ. per ml. [6,11]. It is generally accepted that the single most important factor in local anesthetic toxicity is the peak plasma concentration. Using these criteria, intravenous regional anesthesia is at least as safe as axillary block or lumbar epidural anesthesia on the basis of comparative blood levels among the three techniques. It is generally accepted that patients cannot tolerate a peak blood level above 5 μ. per ml. when they are conscious and 10 μ. per ml. when they are anesthetized[4,5,12]. Factors which control the peak blood level are the concentration of the drug used, total dose and, in the case of intravenous regional anesthesia, the amount remaining in the vessels after absorption by the tissues which can subsequently be washed back into the systemic circulation with deflation of the tourniquet.

In general the central effects of lidocaine after intravenous regional anesthesia have been reported at 2% or less[13,10]. These effects are characterized in the early stages by disorientation, extreme talkativeness, tinnitus, slurring of speech, drowsiness and more seriously, central nervous system depression and/or convulsions. Cardiovascular complications are less likely but significant and again relate in part to the concentration and total dose of the drug selected, plus the particular pharmacologic effect of the local anesthetic on the cardiovascular system.

Prilocaine, which has an amide structure quite similar to lidocaine, is equally potent but only two-thirds as toxic and can be used for intravenous regional anesthesia. It is reported to have better distribution between the cells and extracellular fluids with complete and rapid onset of anesthesia[14]. Detoxification is faster

than lidocaine due to the rapid breakdown of the drug by liver enzymes. Three mg. of prilocaine per kilogram of body weight will give satisfactory anesthesia and this dosage is not associated with significant methemoglobin formation, although the latter has been a reported complication of prilocaine[11]. Methemoglobinemia is not a problem unless a dose greater than 10 mg. per kilogram is administered [13, 15, 16, 17].

TECHNIQUE OF BLOCK

The technique illustrated in Figures 1,2,3 and 4 involves the placement of a tourniquet high on the arm for upper extremity surgery. A scalp vein needle is then introduced in a superficial vein as close as possible to the operative site. The extremity is elevated and exsanguinated with a rubber (Esmarch) bandage. If the cannulated vein is in the hand the application of the rubber bandage is started at the wrist to avoid dislodging the needle. A more expensive alternative to the use of a scalp vein needle is the insertion of a plastic cannula into a vein. The tourniquet is inflated

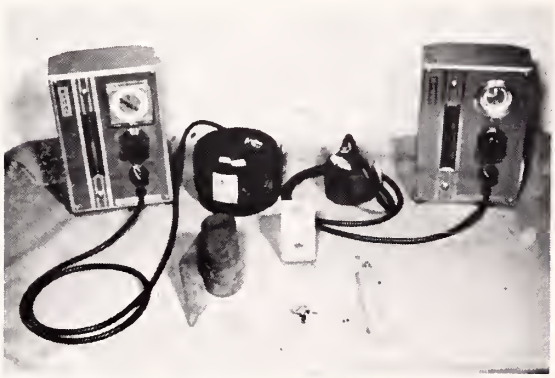


FIGURE 1. Basic equipment necessary for intravenous regional anesthesia.

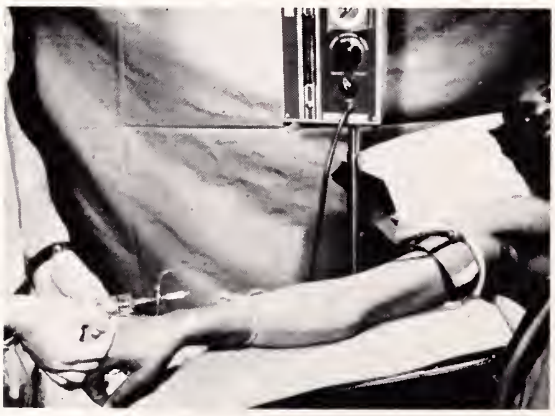


FIGURE 2. A scalp vein needle is inserted as close as possible to the operative site.



FIGURE 3. The extremity is tightly wrapped, tourniquet inflated, and anesthetic injected after unwrapping to isolate the area of surgery.



FIGURE 4. Esmarch bandage is removed, second tourniquet applied, and patient prepared for surgery.

to approximately twice the systolic blood pressure. The operative area is exposed by partially unwrapping the Esmarch bandage, leaving the rest of the extremity tightly wrapped. Three mg. per kilogram body weight of a 0.5% solution of lidocaine or prilocaine is then injected into the vein. The remaining portion of the bandage is removed and a second pneumatic tourniquet placed distal to the first. This tourniquet is inflated and the first tourniquet deflated if the patient experiences tourniquet pain. Onset of analgesia is usually immediate with paralysis of the extremity occurring within 10 minutes. At the termination of the procedure the tourniquet is deflated and sensation can be expected to return completely within 10 to 15 minutes. The procedure is basically identical when anesthesia of the foot or ankle is required. The pneumatic tourniquet is placed on the calf at least three inches below the head of the fibula to avoid compression of the peroneal nerve as it crosses the fibula. The

dose of anesthetic is the same as that used for the upper extremity.

When the extremity is painfully injured and the patient cannot tolerate the application of a rubber bandage over the injury, blood is drained from the extremity by gravity, holding the extremity as high as possible above the level of the heart for 60 seconds followed by rapid inflation of the tourniquet.

MECHANISM OF ACTION

The mechanism of action of this method of anesthesia has not been definitely identified. There are two schools of thought on the matter. One theory states that the block works through the mechanism of blocking peripheral nerves at distal sites [18,19]. The other suggests that the block is due to the interruption of sensory impulse passage through large nerves[20]. The latter has been proven by applying two tourniquets and injecting the local anesthetic between the two tourniquets and demonstrating that peripheral anesthesia below the distal tourniquet does result.

Status Epilepticus

The classical treatment of status epilepticus generally involves the intravenous administration of barbiturates or in some cases muscle relaxants used to paralyze the patient. More recently the anti-convulsant effect of intravenously administered lidocaine has been reported in abolishing attacks of status epilepticus in humans[21]. Normally a 1 per cent solution of lidocaine is used as an intravenous injection at the rate of 1 mg. of lidocaine per kilogram of body weight per hour. This dose has been increased to 4 mg. per kilogram of body weight per hour in some instances, in order to control and/or abolish the attack[22].

The concurrent use of barbiturates in low dosages in conjunction with lidocaine has been reported and served to decrease the toxicity of the latter while avoiding oversedation with the barbiturates[23]. One should be prepared to control the airway and support ventilation if this method of treatment is selected.

Suppression of Cough Reflex and Supplement to General Anesthesia

Steinhaus and Gaskin have demonstrated the efficacy of suppression of cough reflex with the intravenous administration of lidocaine. The average dose of lidocaine reported in their study was 245 mg. although the dose they reported did not appear to be based on body weight[24]. They compared lidocaine and meperidine as depressants of the cough reflex during general anesthesia and concluded that the local anesthetic could completely suppress cough without severe respiratory depression, whereas the opiate caused respiratory arrest in a high percentage of patients before this reflex was suppressed. The technique has not been used as a method of cough suppression in conscious patients and, indeed, has not been recommended for that purpose.

The use of intravenous lidocaine in conjunction with sodium thiopental for laryngoscopy and bronchoscopy has been advocated[25]. The patients were anesthetized with thiopental (2 to 4 mg. per pound and halothane, nitrous oxide and oxygen for four minutes. The patients were then given lidocaine intravenously in the same milligram dosage range as thiopental over a four minute span. The endoscopist was able to insert the laryngoscope or bronchoscope without difficulty in about 90% of cases. Thiopental and lidocaine were given in supplemental doses every three to five minutes and the patient insufflated with oxygen or an oxygen-halothane mixture. This report stated blood gases were unchanged and patients tolerated the procedure well. Blood gas parameters and circulatory studies need to be done in a larger series of patients to prove the safety of this technique before it can be universally recommended.

Others have used essentially the same technique with good results in various operative procedures, but these patients were maintained on nitrous oxide and oxygen via mask or endotracheal tube throughout the procedure[26,27]. The dose of lidocaine varied from 250 mg. to 1000 mg. The primary advantages of the technique were stated to be the suppression of pharyngeal and laryngeal reflexes without respiratory depression, a stable cardiovascular system, and a smooth emergence.

Prevention of Succinylcholine Induced Fasciculations and Muscle Pains

Lidocaine and procaine have been reported to prevent the muscle fasciculations seen after succinylcholine administration[28]. The dose of procaine necessary to produce this result was 6-10 mg. per kilogram with the highest dose preventing fasciculations in ninety percent of patients.

Lidocaine has also been shown to prevent postoperative muscle pain following succinylcholine[29]. Lidocaine, 6 mg. per kilogram, significantly reduced the frequency, intensity and duration of muscle pain following succinylcholine administration. Lidocaine also increased the duration of apnea induced with succinylcholine by about 30 seconds. The above side effects of succinylcholine administration can also be decreased by the prior administration of a nondepolarizing neuromuscular blocking agent.[30] The latter procedure seems easier and associated with fewer potential complications.

Summary

Local anesthetics are used intravenously for several medical indications, both in and out of the operating room. Intravenous regional anesthesia and control of arrhythmias are acceptable uses of these anesthetics.

Intravenous anesthetics for control of status epilepticus, cough reflex suppression, adjunct to general anesthesia, and prevention of succinylcholine induced fasciculations and muscle pains may have a place in medical practice but their permanent niche in the armamentarium of the physician needs additional evaluation.

Bibliography

1. Harrison, D. C., Sprouse, J. H. and Morrow, A. G.: The Anti-arrhythmic Properties of Lidocaine and Procaine Amide. *Circulation* 28:486, 1963.
2. Gianelly, Ralph, von der Groeben, J. O., Spivack, A. P. and Harrison, D. C.: Effect of Lidocaine on Ventricular Arrhythmias in Patients with Coronary Heart Disease. *New England J. Med.* 277-1215, 1967.
3. Grossman, J. I., Lubow, L. A., Frieden, J. and Rubin, I. L.: Lidocaine in Cardiac Arrhythmias. *Arch. Intern. Med* 121:396, 1968.
4. Englesson, S., Eriksson, E., Wahlquist, S., and Ortengren, B.: Differences in Tolerance to Intravenous Xylocaine and Citanest (L 67), A New Local Anaesthetic. A Double Blind Study in Man. *Proc. First European Congress of Anaesth.*, 1962.
5. Foldes, F. F., Molloy, R., McNall, P. G. and Koukal, L. R.: Comparison of Toxicity of Intravenously Given Local Anesthetic Agents in Man. *JAMA* 172:1493, 1960.
6. Bier, A.: Ueber einen neuen Weg local Anesthesie an den Gliedmassen zu erzeugen. *Arch. Klin. Chir.* 86:1007, 1908.
7. Holmes, C. M.: Intravenous Regional Analgesia, Useful Method of Producing Analgesia of Limbs. *Lancet* 1:245, 1963.
8. Kennedy, B. R., Duthie, A. M., Parbrook, G. D. and Carr, T. L.: Intravenous Regional Analgesia; An Appraisal. *Britt. Med. J.* 1:954, 1965.
9. Editorial. *JAMA* 193:300, 1965.
10. Mazze, R. I. and Dunbar, R. W.: Plasma Lidocaine Concentrations After Caudal, Lumbar Epidural, Axillary Block, and Intravenous Regional Anesthesia. *Anesthesiology* 27, 574, 1966.
11. Dunbar, R. W. and Mazze, R. I.: Intravenous Regional Anesthesia: Experience with 779 Cases. *Anesth. Analg.* 46, 806, 1967.
12. Bromage, P. R. and Robson, J. G.: Concentration of Lignocaine in the Blood After Intravenous Intramuscular, Epidural, and Endotracheal Administration. *Anaesthesia* 16:461, 1961.
13. Dawkins, O. S., Russell, E. S., Adams, A. K., Hooper, R. L., Odiakosa, O. A. and Fleming, S. A.: Intravenous Regional Anaesthesia. *Canad. Anaesth. Soc. J.* 11:243, 1964.
14. Scott, B.: Plasma Levels of Lignocaine (Xylocaine) and Prilocaine Following Epidural and Intercostal Nerve Block. *Acta Anaesth. Scand. Suppl.* XVI:111, 1965.
15. Onji, Y. and Tyuma, I.: Methemoglobin Formation by a Local Anaesthetic and Some Related Compounds. *Acta Anaesth. Scand.* XVI:151, 1965.
16. Hjelm, M. and Holmdahl, M. H.: Clinical Chemistry of Prilocaine and Clinical Evaluation of Methaemoglobinaemia Induced by this Agent. *Acta Anaesth. Scand. Suppl.* XVI:161, 1965.
17. Crawford, O. B.: Methemoglobin in Man Following the Use of Prilocaine. *Acta Anaesth. Scand. Suppl.* XVI: 183, 1965.
18. Atkinson, D. L., Modell, J. and Moya, F.: Intravenous Regional Anesthesia. *Anesth. & Analg.* 44:313 (May-June) 1965.
19. Miles, D. W., James, J. L. and Whitman, J. G.: Site of Action of Intravenous Regional Anesthesia. *J. Neurol. Neurosurgery Psychiat.* 27:574, 1964.
20. Sorbie C. and Chacha, P.: Regional Anaesthesia by the Intravenous Route. *Brit. Med. J.* 1:957, 1965.
21. Tavener, D.: Intravenous Lignocaine as an Anti-convulsant in Status Epilepticus and Serial Epilepsy. *The Lancet* 11:1145, 1958.
22. Mosovich, A. and Et Chepareborda, J.: The Effect of Xylocaine Upon the Bursts of Paroxysmal Activity in the E.E.G. of Epileptics. *Acta Neurologica Scandinavica* 40:13, 1964.
23. Bernhard, C. G., Bohm, E. and HojeBerg, S.: A new Treatment of Status Epilepticus—Intravenous Injections of a Local Anesthetic (Lidocaine). *A.M.A. Arch. of Neurology and Psychiatry* 74:208, 1955.
24. Steinhaus, J. E. and Gaskin, L.: A Study of Intravenous Lidocaine as a Suppression of Cough Reflex. *Anesthesiology* 24:285, 1963.
25. Blancato, L.S. and Peng, A.T.C.: Intravenous Lidocaine with General Anesthesia for Endoscopy. *Arch. Otolaryngology* 85:103, 1967.
26. Steinhaus, J.E. and Howland, D.E.: Intravenously Administered Lidocaine as a Supplement to Nitrous Oxide-Thiobarbiturate Anesthesia. *Anesth. & Analg.* 37:40, 1958.
27. Aldrete, J.A. and Fraser, J.G.: Intravenous Lidocaine as a Supplement to Nitrous Oxide Anaesthesia for Radical Middle Ear Surgery. *Can. Anaes. Soc. J.* 13:397, 1966.
28. Wekenski, R. et al.: Prevention of Succinylcholine Fasciculation with Local Anesthetics. *Anesthesiology* 26:3, 1965.
29. Usubiaga, J.E. et al.: Intravenous Lidocaine in the Prevention of Postoperative Muscle Pain Caused by Succinylcholine Administration, *Anesth. & Analg.* 46:225, 1967.
30. White, D.C.: Observations on the Prevention of Muscle Pain After Suxarmethonium. *Brit J. Anaesth.* 34:332, 1962.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



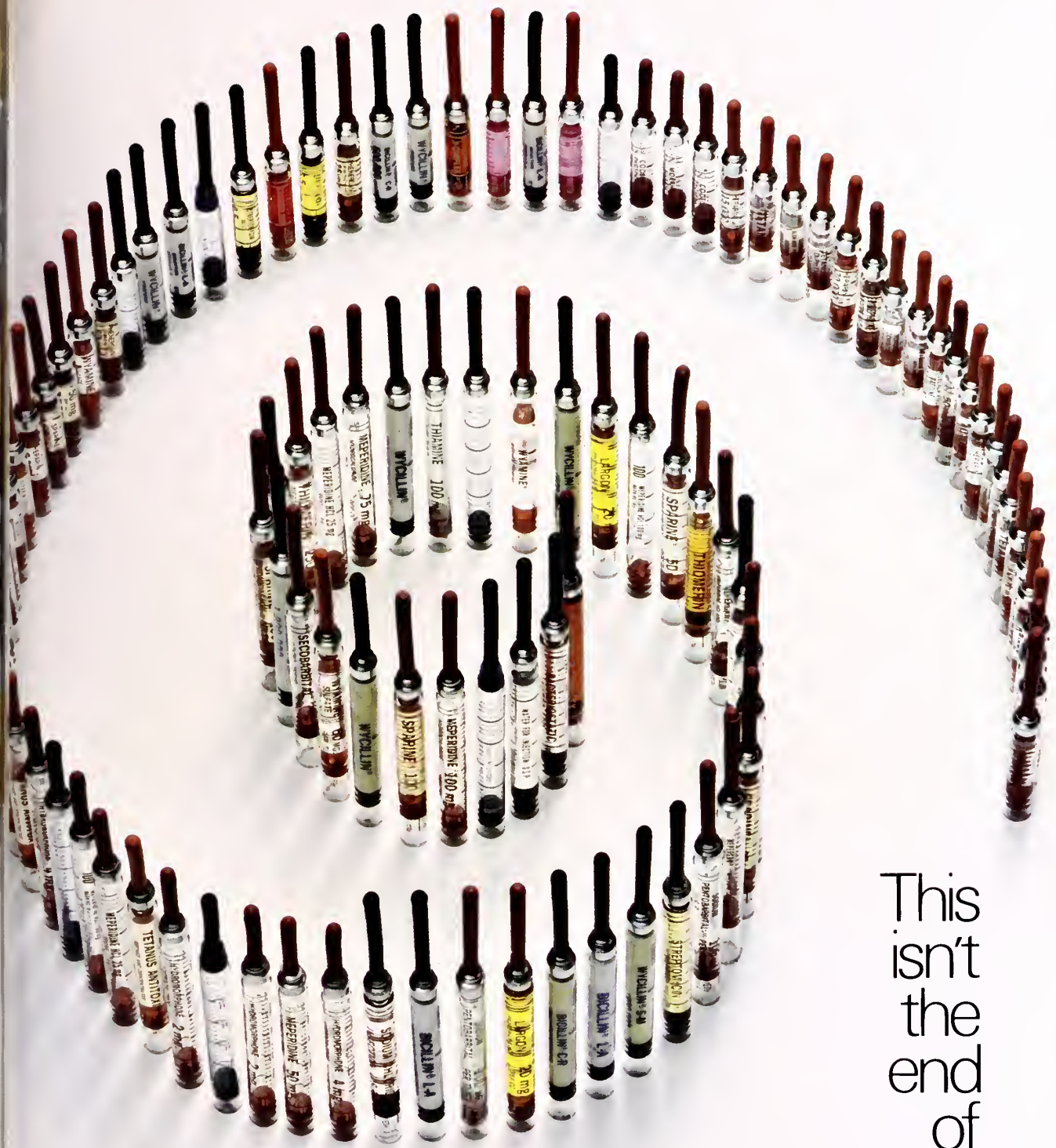
Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet





This isn't the end of the line.

(New TUBEX® are constantly being added)



Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
- **convenience**—no filling, no needle-sharpening, no sterilization, no cleanup
- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
- **acceptability**—presharpened, siliconized needles lessen pain of injection; patients appreciate single-use equipment

Just select, inject, throw away

TUBEX®

sterile cartridge-needle unit

Wyeth Laboratories Philadelphia, Pa.

Wyeth®

UD UNIT DOSE MEDICATION

Laryngeal Blastomycosis†

Edward J. Fadell, M.D., George I. Uhde, M.D.
and Charles C. Smith, M.D.

Louisville, Kentucky

A case of blastomycosis presenting as hoarseness with a laryngeal lesion is reported to illustrate that this lesion, seen frequently in Kentucky, has many primary manifestations.

CONANT[1] defines North American blastomycosis as a chronic infection, caused by Blastomyces dermatitidis, characterized by the formation of suppurative and granulomatous lesions in any part of the body but with a predilection for the skin, lungs, and bones. Furcolow[2] states that Kentucky has the highest incidence of this disease in the United States. In reports from this state, the most common lesion is cutaneous.

Laryngeal blastomycosis has been regarded as a rare site of the disease. In a review by Kunkel et al.[3] eight reported instances of such involvement were described together with an additional four cases which were on record at the Mayo Clinic. More recently, Witorsch and Utz[4] in a comprehensive review cite two instances. Kunkel suggested that laryngeal lesions are not being recognized or are not being reported. In view of the paucity of laryngeal blastomycotic involvement, the following case is reviewed.

Report of Case

This 39-year-old white male was seen in November 1966 by his family physician for pharyngitis. This was diagnosed as Streptococcal in type and was treated with antibiotics. At this time hoarseness was noted which was periodic until February, at which time the hoarseness became persistent. He was referred to an otolaryngologist. Indirect laryngoscopy revealed a growth involving the entire left vocal cord extending into the anterior commissure. Extension to the ventricular fold was present. However, there was no subglottic extension. The left vocal cord had no fixation. The clinical impression was epidermoid carcinoma of the left vocal cord. On 5-31-67, under general anesthesia, a Hollinger adult laryngoscope was passed and a superficial excision of the growth was accomplished. Microscopic examination of this tissue revealed one surface of the section to be lined by markedly thickened stratified squamous epithelium with irregular acanthotic downgrowth in the form of pseudoepitheliomatous hyperplasia. In the loose underlying connective tissue stroma numerous acute and chronic inflammatory infiltrates with abundant histiocytes were present. Giant cells were frequent, many of which were of the Langhans' type. Within these cells vacuoles were noted containing walls. Gomori methenamine silver nitrate fungus stain on duplicate sections revealed the organism to have single, broad-based budding with the morphology characteristic of Blastomyces. (Figure 1) Cultures confirmed this observation.

Hematological and biochemical blood studies were normal. Roentgenograms of the chest were also normal.

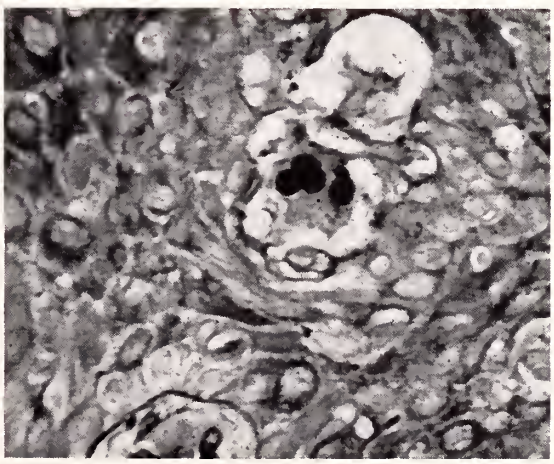


FIGURE 1. Broad based, budding yeasts occupy a giant cell surrounded by acanthotic squamous epithelium. (Gomori methenamine silver stain. x450.)

†*From the Methodist Evangelical Hospital, Louisville*

The only significant historical observation was that the patient worked as a mailer for the local newspaper. The papers were stacked by machine which created a large amount of dust.

Amphotericin therapy was instituted with an initial dose of 20 mgm. daily for three days, then increased 5 mgm. daily until 50 mgm. per day was reached. A total of 1110 mgm. was administered. On 7-15-67, the vocal cord lesion was much improved. His speech was much better but on examination slight thickening of the cord persisted. He is being followed with periodic chest x-rays and physical examination for the possible development of lesions elsewhere within the body.

Discussion

Gilchrist in 1894[5], described the microscopic appearance of the causative organism of North American blastomycosis at the meeting of the American Dermatological Association. Following much confusion there is now general agreement that the proper name for the organism is Blastomyces dermatitidis. On blood agar at 37°C growth is slow with the development of wrinkled, waxy colonies. Microscopy shows budding yeast-like cells, with abortive attempts at development of mycelia. On Sabouraud's glucose agar at room temperature a mycelial phase predominates, with the development of a white cottony growth which becomes tan to brown with age.

Examination of excised tissue with routine hematoxylin and eosin staining reveals the fungus as a rounded structure having a double-contoured appearance. A marked proliferation of the overlying squamous epithelium with pronounced acanthosis is present. Confusion with carcinoma is possible. Subjacent and about this acanthotic pseudoepitheliomatous proliferation a granulomatous infiltrate consisting of lymphocytes, polymorphonuclear leukocytes and epitheloid cells are present. Giant cells of the Langhans' type are frequent. The single broad-based budding blastomycete is diagnostic. Special stains in the form of the periodic acid-Schiff or those employing silver are helpful in identification.

The mode of infection by Blastomycoces dermatitidis is elusive. Attempts at isolation from soil in areas in which infected persons have lived have been negative. The only recent pertinent observation has been that the infection is endemic within dogs in Kentucky[6].

In autopsy studies of known infections, approximately 95% of the cases have a pulmonic lesion. Pulmonic involvement evidently occurs by inhalation. Although there is a high incidence of pulmonic involvement, the clinical symptomatology is related to organism dissemination and localization. If this localization is predominantly pulmonic, as is noted in one-third to one-half of the cases, fever, cough, and expectoration of purulent, foul-smelling, sometimes bloody sputum may be noted. Asymptomatic pulmonic lesions often are found on x-ray films after other lesions develop. The term "disseminated" is applied to systemic mycoses other than pulmonic.[2] The skin and bone are the most prominent sites. The genitourinary system is less frequently, although not uncommonly involved. Epididymitis, in all probability, is the most common genitourinary condition encountered. Involvement of the central nervous system has been well described and Gilchrist initially confused B. dermatitidis with Torula.[3] The gastrointestinal tract appears more resistant. As noted in the introductory statements, laryngeal involvement has very infrequently been reported.

The manifestations of laryngeal involvement are usually those of any lesion interfering with phonation. Hoarseness is the most common observation, although neck swelling may be noted as a result of associated cervical lymph node enlargement. The primary differential diagnosis is carcinoma, both clinically and histologically.

Although difference of opinion exists concerning chemotherapy of this infection, amphotericin B is active against the organism and the likelihood of relapse of infection is less when 20 gm. are given. The major objection to amphotericin is its toxicity, especially renal impairment. 2-hydroxystilbamidine is also effective and may be used in the future.[4]

References

1. Conant, F. N., et al: *Manual of Clinical Mycology, 2nd Ed.* Phil. and London. W. B. Saunders Company, 1963.
2. Furcolow, M. L. et al: Blastomycosis. *JAMA* 198:529, 1966.
3. Kunkel, W. M. et al: North American Blastomycosis — Gilchrists's Disease: A Clinicopathologic Study of Ninety Cases. *Int. Abst. J. Cut. Dis.*, 12:496, 1894.
4. Witorsch, P., and Utz, J. P.: North American Blastomycosis: A Study of 40 Patients. *Medicine*, 47:169, 1968.
5. Gilchrist: Protozoan dermatitis. (Review of paper in Transactions of the American Dermatological Association). *J. Cut. Dis.*, 12:496, 1894.
6. Furcolow, M. L.: *Personal communication.*

SPECIAL ARTICLES

What Has the AMA Ever Done for You?

DAVID B. WEIHAUPT*

AS YOU know, and as I well know, the questions are asked many thousands of times per year by physicians—What is the AMA doing? What have they ever done for me? What's going on at 535 North Dearborn? What am I getting for my dues?

I think these questions are rightly asked, for a membership card in the AMA does not automatically endow its holder with a sophisticated knowledge about the functions and purpose of the AMA. I do believe that the answers to these questions are available, throughout the course of the year, but they're supplied in a piece-meal basis of letters, pamphlets, and literature that come through the mail, most of which, physicians do not have the time to read, as you well know. I am offering the correct information, facts and figures about the American Medical Association and what it is doing for you, the public, and for the nation as a whole—the truth, if you will. I hope you accept what I say, as well as many people apparently accept the fallacies printed about us in local newspapers and national magazines. I am confident I can prove to you that the AMA is a tremendously functionable and productive Association doing an enormous job in serving the profession and the people of this country.

In the following information, I would like to ask you to read into the facts and figures, the benefits that you have and will derive from what we're doing. The general purpose of the Association, is of course, to promote the science and art of medicine and the betterment of public health. I think the following will prove that this is the truth.

I will not defend, apologize, or excuse AMA, its policies, or philosophy, which may be different from yours, or the lost battles of the past.

Now let me give you the following information and facts, not in the expectation that you will remember them, but in hopes that you will comprehend the whole picture and carry it in your philosophy to your community, your friends, and physicians of your county medical society. These figures come from the AMA and not through your local newspapers.

A. There are approximately 317,000 physicians in this country, of which 215,000 are AMA members.

B. Of these, only 164,000 are dues-paying members and not all are full dues-paying members.

C. Approximately 28% of our total budget is from physicians' dues. The remainder we have to plan, program, and work for through our advertising and exhibit revenues.

D. Your dues of $70 would have to be over $220 to make up the needed funds to operate if it weren't for the abilities and the hard work of the people at AMA in obtaining these revenues.

E. Approximately $5 million of the budget goes for salaries for the 922 employees. In these group are physicians, attorneys, chemists, journalists, biostatisticians, and accountants who are high calibre people.

F. We have real estate taxes of approximately $275,000 and social security payments of approximately $350,000.

The AMA is one of the world's largest publishers, and about $12 million of our budget goes into paper, printing and mailing. I ask you to consider all the following figures on a basis of a cost of 11¢ per page to produce and mail. These costs, by the way, are up approximately 181% in the last seven years. I would like you to consider the following as benefits not only to the general public, and AMA members, but also as benefits derived by non-members, for AMA serves the profession, as a whole.

1. Since 1960, over 3 million pieces of literature have been sent to students of medical schools.

2. The AMA NEWS has a circulation of approximately 340,000 and is published each week. That's about 17 million newspapers per year. Each physician, member or not, members of Congress and major newspapers all over the country receive copies.

3. We have approximately 3,500 different pamphlets—child care, health education, health tips, sex education and many others. We send out over 100,000 copies per year of each of the major pamphlets and thousands of the others.

4. We have sent out over 2 million copies of the AMA First-Aid Manual in the past several years.

5. We publish 10 specialty journals with a circulation of 226,000 and we recently released 311,000 pieces of mail to physicians in this country on health education materials.

6. Every two years, we publish the AMA Directory, 6,500 copies, which contains biographical and

*Member, Division of Public Affairs, American Medical Association, Chicago, Illinois

educational data on every licensed physician in the United States. It is a three-volume set and they are sent to every state and county medical society, all journal editors, and the libraries of 94 medical schools.

7. The magazine "Today's Health" comes out monthly with a circulation of 700,000 each month, a mailing of about 8½ million magazines each year.

8. "Horizons Unlimited" on health careers has been sent in quantities of tens of thousands to schools, colleges, and medical societies, free.

9. In one month, we sent out 30,000 copies of our booklet "Selective Service, Military Service, and the MD", to medical schools and other organizations requesting it.

In addition, you may be familiar with our books "Current Medical Terminology" and "New Drugs", which are sent out by the thousands each year.

10. JAMA, the Journal of the American Medical Association, has a circulation of 219,000, and it comes free to all members of the AMA. This, "Today's Health", AMA NEWS, and the specialty journals cost the AMA about $50 per year to send to each physician member. The AMA specialty journals and JAMA are published by the McCall Corporation in Dayton, Ohio. With all these publications and materials distributed, the members of the AMA carry some of the burden of the nonmembers.

11. Each year, thousands of manuscripts are submitted to us for review, and actually, we are able to publish over 1,000 each year.

12. We check over 500 medical publications each month for useful information to relay to you through our publications.

13. In 1967, over 25,000 copies of "Winning Ways With Patients" were sent free.

This is actually a small percentage of the tremendous publishing, printing and mailing burden that we have every year, and this is done for the benefit of the public, the medical profession, component societies, and other organizations in the country. The natural question is—Why all this paper?

The reason is that these publications have been asked for by the 242 members of the AMA House of Delegates, by the public of this country, the schools of the nation, allied health professions and health institutions, and also the more than 1,900 state and county medical societies. We publish these materials as answers to the needs of these organizations. As a result of the asking by these organizations, we research, plan, design, publish, print, and mail these tens of millions of pieces every year. Literally thousands of pieces of different types of material are relayed to your component medical societies. Information on legislation, state laws, federal laws, plans and programs of the AMA, and just normal everyday correspondence between component organizations. I realize this is a lot of time, work and a lot of paper, but this is the responsibility of the AMA to the people of this country, and it is a responsibility that we must keep, or would you have us yield and give this job to someone else—shall we say, industry, state government, the federal government, or labor. Who else but the AMA is more qualified, more dedicated, more capable and more unbiased to do this job for the physicians and the people of this country—and the job must be done.

I gave you small packaging of the total statistics available and what actually goes out of the AMA. Now for some of the things that come into the AMA.

1. In one day, there are 1,000 long distance and many more local calls coming into our office.

2. Over 21,000 pieces of first class mail are handled by the AMA every day. This is about 6 million pieces of mail every year. Consider the fact that to serve membership and the public, it takes people to receive, open, distribute, reply to and file this enormous load of correspondence.

3. Each year, we receive 30,000 requests from the general public for help and information, and we get many thousands more requests for information and help from physicians, the profession—not just members.

4. In our card catalog of physicians, there are 6,000 changes every week in physicians' home and office addresses.

5. The Archive Library of the AMA handles in an average month:

A. 2,400 research requests
B. 750 requests for books
C. Loans of 400 library items
D. Photocopying and mailing of approximately 19,000 pages of material
E. 40,000 books in the Library itself
F. 2,500 periodicals
G. 610 magnetic tapes with medical information
H. In the film library, there are 500 films, available to the public, medical societies and the individual physician to be used in learning or speaking. A cross file in the film library has over 7,000 cards. Although you may never use these benefits, tens of thousands of people do each year, and will in the future. They are available for you.

6. The film "Medical Careers" has been shown 90,000 times and the film "Careers Unlimited" has been shown over ¼ million times. A new film called "Faith" is being made and publicity spots have been sent out to over 2,000 radio stations. Recently, we sent out health tips to over 600 TV stations and 2,600 radio stations—a 60 second spot, for the public benefit.

7. In the past year, we have arranged for over 1,300 health films to be shown 32,000 times at 7,000 appearances before 13 million people.

Conceivably these are very boring figures, but if you consider them carefully, you will see the enormous job that the Association is doing in almost all fields of medicine. It would be a wonderful thing if the general public and physicians had an awareness of this enormous job. Then, the many misconceptions about the AMA would most certainly be cleared up.

8. We have designed and built 110 medical exhibits for use by the public, medical societies, and medical schools. Some of them were at the Kentucky Medical Association Annual Meetings last year and this year.

9. I am sure many of you are familiar with the page, the "Legislative Roundup" which goes to all state, county medical societies, and physician leadership in the states. It is a one-page piece with a brief summation of the status of current legislation in Washington.

10. It is hoped that in the near future, we can initiate a new program called "Report of the Nation", which will be a coast-to-coast one-hour network TV program put on 3 or 4 times a year by the AMA to provide accurate and truthful information to the public. We doubt that we will be able to afford equal time with the President of the United States.

Now I have covered what goes out of AMA, also what comes in. Here is more information on what goes on in the AMA. Considering the preceding, it's possible that these questions have already been answered. But let me continue.

1. There are over 1,000 meetings held every year and over 800 physicians serve without pay on the 80 commissions, councils, and committees. That's one physician for every 200 in the country. There are 80 committees, 16 councils, 4 commissions, 22 scientific sections, 10 specialty journals, 50 departments and 8 divisions, which are the Communications Division, Law Division, Management Services Division, Scientific Activities, Scientific Publications, Health Service, Medical Education, and my Division, Field Service. Under these are the Council on Drugs, Committee on Quackery, Committee on Cutaneous Health and Cosmetics, Committee for Research on Tobacco and Health, and on and on to a total of 80. All of this was created by the actions of the House of Delegates, for the needs of medical societies, the general public and the profession.

2. Throughout the course of the year, we sponsor 400 scientific lectures, 400 scientific exhibits at the Annual and Clinical Sessions and 300 exhibits on New Drugs. There were 39,000 registrants at the 1967 Annual Meeting in Atlantic City and these people had an opportunity to see the latest developments in American Medicine.

3. I am sure you have heard of the AMA-ERF Student Loan Program, sponsored by the AMA. Under this program, the AMA has arranged over 45 million dollars in loans, involving 28,000 separate loans to 19,000 medical students, interns and residents. In Kentucky alone, we've arranged over 852 loans encompassing over $963,000.00 to your medical students. The average physician contribution in this country is $2.50. Since 1955, we have received and distributed over $35 million to medical schools in this country. We have Councils and Committees who are also working very hard to increase the enrollment in medical schools, expansion of the facilities of those that exist, plus assisting in the forming of new medical schools. Sixteen are now in the making, and AMA has made major contributions to their beginnings.

4. Woman's Auxiliary, with headquarters at AMA, has received and distributed over $3 million for medical schools and $4 million to the Student Loan Program.

5. We have also available some direct benefits, such as the AMA Retirement Program and the Disability Program that physician members can take advantage of.

6. Our Speakers' Services Department writes and supplies speeches and other materials for research for physicians throughout the country and officers of the Association. We also supply building plans, partnership agreements, and a variety of other services are at the disposal of physicians.

7. Our Communications Division has literature, program aids, films, speeches, press materials, and other services available to state and county medical societies, as well as physicians. For the Director of the Communications Division, there is an advisory committee which consists of state executive secretaries. Mr. Joe Sanford was a member, who lended a respected voice to this Committee and their programs for many years till his recent untimely death.

8. The Department of Medicine and Religion consists of a four-man staff working with medical schools, theological seminaries, hospitals, physicians and clergy in a very successful attempt to bring together the healing of the body and soul.

9. As I mentioned earlier, there are over 1,000 meetings held by AMA each year. Just to give you an idea of what these meetings are week to week, beginning June 10 through June 17, the following were scheduled:

A. Regional Workshop for State Chairmen of Medicine and Religion
B. Committee on Planning and Development
C. Conference Committee on Graduate Training and Surgery
D. Symposium on Exercise and Heart
E. Residency Review Committee on Neurological Surgery
F. Committee on Environmental Health
G. Committee on Aerospace Medicine

This schedule of meetings goes on 52 weeks a year including weekends, once again to serve the purpose of advancement of the science and art of medicine and the betterment of public health. These and all others cannot be eliminated for we would sacrifice not only the well being of the profession and public health, but the leadership of the physicians in medicine.

10. Undoubtedly, you have heard of the American Medical Association Institute for Biomedical Research. This was created by the AMA House of Delegates. There are 30 scientists doing research in immunology, medical ecology, virology, molecular biophysics, regulatory biology and neurobiology. This, too, is a service to all mankind.

11. Project Viet Nam is a program initiated by the federal government, which was not functioning

too well, naturally, and the government asked the AMA to take it over, naturally. It is a program whereby physicians volunteer to go to Viet Nam and serve the civilian public of that nation. In two years since we have been handling the program, approximately 293 physicians have served in Viet Nam. Last month alone, we had 75 inquiries and 28 applications were filed. This month there were 9 physicians going to Viet Nam to serve under this program.

One of the most active divisions of the AMA is the Law Division which supplies to all departments and the Board of Trustees and the physicians throughout the country, legal opinions, guidance, information on medical liability, taxation, insurance, advertising, copyrights, and specific information on libel and slander. Thousands of physicians write every year and receive guidance on state problems, retirement problems, partnership agreements, and federal and state laws. Under the Law Division, the Department of Investigation wages a relentless battle against quacks and charlatans throughout the country, as a service to the public health and the profession.

12. Let me briefly give you the box score of the AMA Political Action Committee, which was involved in 131 Congressional races in 1966. Of those, 104 races were successful. They were involved in 15 Senate races, and won 13 of them, and some of these major victories were made in the state of Ohio as a result of the tremendous and effective effort of your Ohio Medical Political Action Committee.

And now, after all this information about the AMA and its services to the physicians and the public of this nation, I would like to discuss that which the press dearly likes to write about as a major and almost total function of the AMA — The Washington Lobby.

Some say all they do is try to enhance the income of physicians of this country. They write about this group, the Lobby, as a huge multi-million dollar organization — those, who it is written, hate children, old people, the unborn, handicapped, and the poor. This is a huge, unjust burden which we carry. When this Lobby tries and succeeds in excluding the disabled persons from the new social security amendments, the press of this country generally says that the physicians hate the handicapped. In truth, these unfortunate people are not only treated free or at a decreased charge by physicians, but they're also covered under Title XIX of Medicare, and several other federal and state programs. This is a prime example of federal duplication. Only a fraction of one percent of the budget of the AMA goes to lobbying. Let me tell you more about this so-called multi-million dollar lobbying staff. In truth, it consists of four full-time registered lobbyists. Yes, we have only four men in Washington compared to Labor's 125 registered lobbyists and 300 unregistered lobbyists. Each of our four men has 12 senators and approximately 110 congressmen to learn about, work with and convince. A small force indeed. But don't let me minimize their abilities, their influence, their effectiveness and their successes. They do an outstanding job and this can be proven by our past and present successes in Washington. It can also be proven by some of the adverse publicity that we get. There were some rather uncomplimentary quotations in one of the nation's leading magazines not too long ago. Senator Stephen Young (Ohio) referred to this huge AMA lobby in the November, 67 issue of *Playboy Magazine,* as follows: "One of the slickest, best financed in the nation" and "it has been the spendingest lobby in Washington in recent years." Not only is his choice of words uncomplimentary, but inaccurate.

So you can see, we have immunity nowhere and it is popular to discuss this huge four-man lobby in *Playboy,* adding sophistication to the magazine, and supposedly some degree of credence by quoting Senator Young, though his statements were gross inaccuracies.

Let me give you some information on what this lobbying staff is really up against and what it really does. In the 89th Congress, there were 26,500 bills introduced of which 1,600 had health implications. The AMA offered information and opinions on 33 of these bills, and contrary to popular belief, we favored 21, partially favored 5, and opposed only 7. In the first session of the 89th Congress, there were 850 bills with medical implications, but in the first session of the 90th Congress, there were over 1,126 bills pertaining to health. We have one man in Washington to analyze these bills. Back in Chicago, there are three men to corrolate policy and position and testimony on these bills, and to establish a position as to the impacts of the legislation on physicians of this country and the general public. I wish to point out that a great deal of the work done in Washington by our staff is for the benefit of the science of medicine and that these men supply basic medical information to members of Congress, for themselves and for the people of their district. They also help the legislators obtain family physicians when they move to the District of Columbia.

Now, a little about my Division — Division of Public Affairs — The Washington office is part of this Division, and we headquarter in Chicago. There are 12 men covering the United States, also Puerto Rico (The Virgin Islands) and as far away as Alaska and Hawaii. We work in person-to-person contact with staff and leadership of state and county medical societies. I personally cover Ohio, Kentucky and Indiana. A great percentage of my function is in the legislative and lobbying area. In our work, we interpret and promote the activities and services of all AMA Departments to component societies, and, in turn, familiarize AMA with the programs, problems, needs and opinions of component medical societies, and the public, physicians and physician leadership.

But when I am asked "What do I get for my dues?", if I don't have the time to give a speech, my short reply is "Nothing". Who said that the $70 in dues would come back to the member January 1 each year as a short term capital gain? The AMA

(*Continued on page 71*)

EDITORIALS

Tuberculosis Eradication in Kentucky †

THE crisis of continued high incidence of new cases of tuberculosis in Kentucky is being met by the cooperative effort of many. Particularly active have been the Kentucky State Health Department, the Kentucky Tuberculosis Hospital Commission, the Kentucky Tuberculosis and Respiratory Disease Association, the Kentucky Thoracic Society, the Community and Pulmonary Disease sections of our medical schools and the Kentucky Medical Association.

In 1961 the First Kentucky Conference on Tuberculosis Eradication was held in Lexington. Emphasis was placed on detection and treatment of every active case of tuberculosis in the state and specifically the conference recommended "tuberculin skin testing be done on all children under the age of fourteen"; "mandatory tuberculosis case detection be required for admission to the public schools"; and "screening surveys be concentrated on those population groups with a high tuberculosis prevalence."

In 1965 the Second Conference on Tuberculosis Eradication more strongly recommended "that tuberculin testing be undertaken as a case-finding tool with a minimum program to include testing of all school children and investigation of contacts, then the testing of industrial and other adult captive groups, then testing the entire population group preferably by county with all persons with positive tuberculin reactions being x-rayed and suspects referred to tuberculosis clinics". It was further recommended "that eradication projects similar to the Martin County Project be set up in each of the tuberculosis hospital districts (of which there are six in the state) which would serve as centers of eradication and demonstration for each district".

In 1963 the Martin County Project, a pilot program of tuberculosis eradication, was initiated in Martin County, Kentucky as a joint investigation by the University of Kentucky Department of Community Medicine, the State Tuberculosis Hospital Commission, the State Health Department, the Kentucky Tuberculosis and Respiratory Disease Association and the Blue Grass TB and RDA. Nearly 95% of the 9,338 persons in the county cooperated. Tuberculin skin tests were given with appropriate follow-up studies of the positive reactors. Immediately following this, certain of the positive reactors were selected for prophylactic chemotherapy—actually 14.5% of the total population—purposing to prevent the predicted breakdown in this high risk group. Selected for prophylactic isoniazide therapy were individuals with positive tuberculin skin reactions and abnormal chest x-rays though with negative bacteriological studies; those with large reactions to tuberculin (over 20 mm to the intradermal test); and all those with 10 to 19 mm reaction to the intradermal test except for non-contact children ages 5 to 14 years and non contact females over 35 years of age unless diabetic, silicotic, pregnant or on steroids.

In February 1964 a sub-committee of the American School Health Association was formed in Kentucky. In keeping with a child centered tuberculosis detection program, the testing of all school children, grades one through 12, was advocated with follow-up of all positive reactors and their contacts and treatment of all active disease including recent tuberculin converters. Since instigation of this program over 360,000 school children have been tested. With the help of a U.S. Public Health grant, the Health Department and

†*See article relating to this topic beginning on page 33.*

the Tuberculosis Hospital Commission are in the process of initiating a computerized method of record keeping for the Kentucky School Tuberculin testing program. The computer will provide a statistical summary of screening and re-testing, a list of positive reactors by grade and a summary of testing by school and by county. The goal of eradication of tuberculosis in Kentucky may not be realized in the immediate future. We believe, however, that progress is being made and Kentucky's child centered tuberculosis control program, which can result in a generation of tuberculosis germ free children, is a giant step in the right direction.

R. E. Mardis, M.D.

A Face Lifting at Sixty-Six

With this issue of *The Journal* the editors have made some changes in the cover. The color has been changed to blue and the word "Kentucky" has been given emphasis in the title.

The present title, "The Journal of the Kentucky Medical Association," was adopted in November, 1964. From May, 1950 through October, 1964, the title was "The Journal of the Kentucky State Medical Association." From June, 1904, through April, 1950, the publication was known as "Kentucky Medical Journal." The first issue of the publication which appeared was in June, 1903, and had the title of "Bulletin, Kentucky State Medical Association." The original title remained through May, 1904.

The first issue in June, 1903, of the "Bulletin, Kentucky State Medical Association," contained the minutes of the Forty-Eighth Annual Meeting held at Louisville, April 22, 23 and 24, 1903. It also contained the proceedings of the House of Delegates, the annual address of the President, W. W. Richmond, M.D., Clinton, the annual oration in medicine entitled "Serum Therapy," by John G. Cecil, M.D., Louisville, and the annual oration in surgery, entitled "General Anesthesia," by John A. Lewis, M.D., Georgetown.

In the editorial section of the first "Bulletin," note is made that prior to 1903, the transactions of the Kentucky State Medical Association appeared in the form of an annual volume. It is pointed out that the State Associations of Michigan, New York and California had recently changed from publication of annual transactions to monthly journals with "the result of the greatest encouragement and satisfaction."

The advertisements in old journals are always interesting and in the first issue of the "Bulletin" there are several full-page advertisements. The Arthur Peter Company of Louisville advertises "Syrupus Roborans" and "Peter's Peptic Essence Compound," as well as "Febri-Tone" which is indicated in "All Malarial Conditions." The Denver Chemical Company has a full-page ad for "Antiphlogistine." In the second issue of the "Bulletin," July, 1903, the Motor Vehicle Company of Louisville advertises new Cadillacs for $750.00 and the Sutcliffe Company of Louisville advertises new Oldsmobiles for $650.00.

Looking through the early issue of the "Bulletin" and "The Journal" causes one to reflect upon the amazing changes that have occurred in medicine during the course of one lifetime. The first "Bulletin" was printed and published under the direction of a Committee on Publication whose members were James B. Bullitt, Louisville, Arthur T. McCormack, Bowling Green, and J. E. Wells, Cynthiana. You wonder what the reactions of these three men would be if they could now be told that "The Journal" appears in libraries of all 50 states and in 16 foreign countries.

Walter S. Coe, M.D.



roducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M may be better to start on and easier to stay on.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

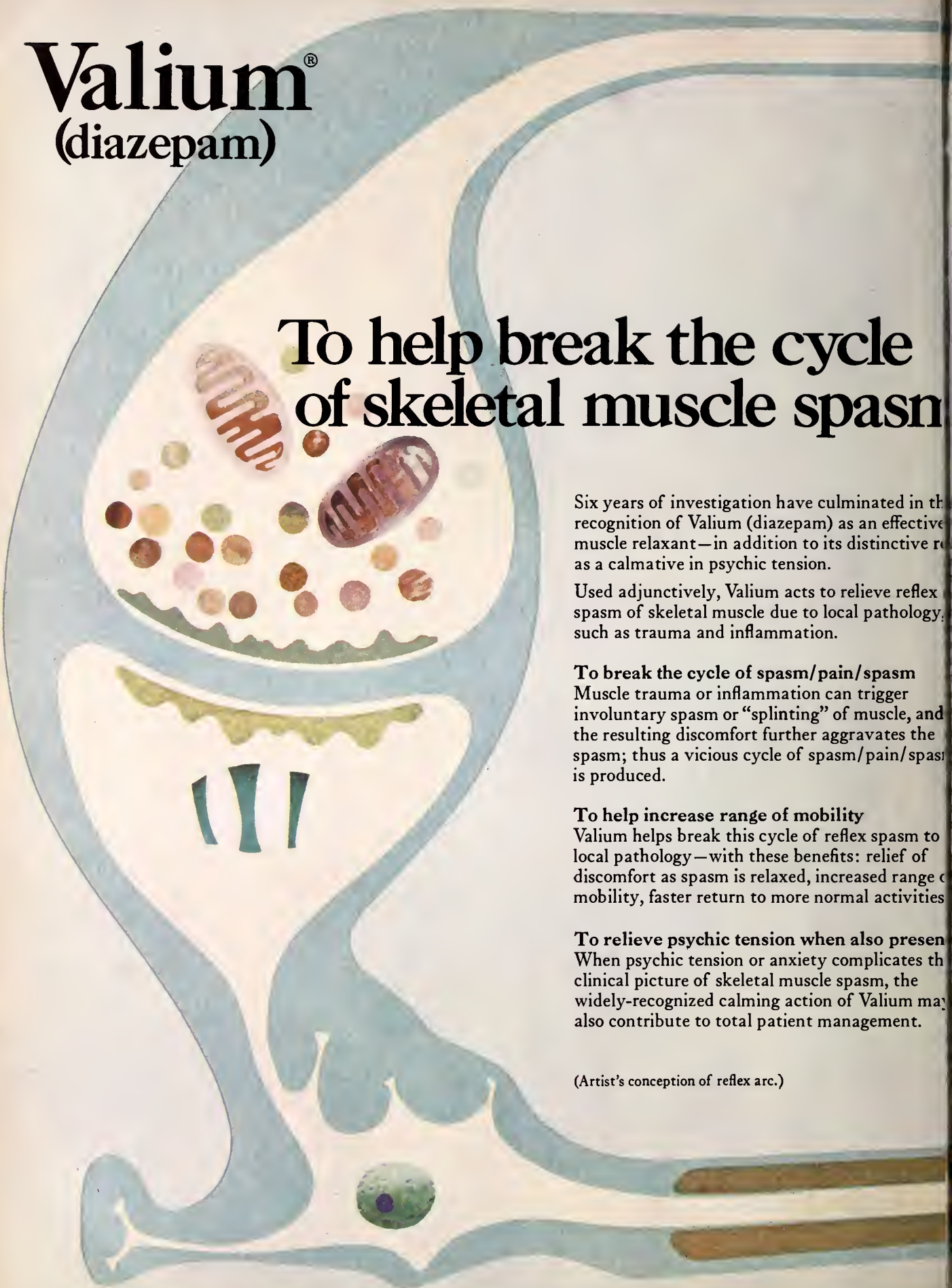
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Valium®
(diazepam)



To help break the cycle of skeletal muscle spasm

Six years of investigation have culminated in the recognition of Valium (diazepam) as an effective muscle relaxant—in addition to its distinctive re as a calmative in psychic tension.

Used adjunctively, Valium acts to relieve reflex spasm of skeletal muscle due to local pathology, such as trauma and inflammation.

To break the cycle of spasm/pain/spasm
Muscle trauma or inflammation can trigger involuntary spasm or "splinting" of muscle, and the resulting discomfort further aggravates the spasm; thus a vicious cycle of spasm/pain/spasm is produced.

To help increase range of mobility
Valium helps break this cycle of reflex spasm to local pathology—with these benefits: relief of discomfort as spasm is relaxed, increased range of mobility, faster return to more normal activities.

To relieve psychic tension when also present
When psychic tension or anxiety complicates the clinical picture of skeletal muscle spasm, the widely-recognized calming action of Valium may also contribute to total patient management.

(Artist's conception of reflex arc.)



ore prescribing, please consult complete duct information, a summary of which follows:

lications: Tension and anxiety states; somatic ıplaints which are concomitants of emotional :ors; psychoneurotic states manifested by sion, anxiety, apprehension, fatigue, depressive ıptoms or agitation; acute agitation, tremor, rium tremens and hallucinosis due to acute ɔhol withdrawal; adjunctively in skeletal scle spasm due to reflex spasm to local hology, spasticity caused by upper motor ıron disorders, athetosis, stiff-man syndrome, vulsive disorders (not for sole therapy).

ntraindicated: Known hypersensitivity to the g. Children under 6 months of age. Acute row angle glaucoma.

ırnings: Not of value in psychotic patients. ıtion against hazardous occupations requiring ıplete mental alertness. When used adjunctively :onvulsive disorders, possibility of increase in ıuency and/or severity of grand mal seizures y require increased dosage of standard anti- vulsant medication; abrupt withdrawal may ıssociated with temporary increase in frequency l/or severity of seizures. Advise against ultaneous ingestion of alcohol and other CNS ressants. Withdrawal symptoms have urred following abrupt discontinuance. Keep liction-prone individuals under careful veillance because of their predisposition to ɔituation and dependence. In pregnancy, tation or women of childbearing age, weigh ential benefit against possible hazard.

:cautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, or 10-mg tablets, t.i.d. or q.i.d. and when skeletal muscle spasm and psychic tension interfere with sleep: add 1 tablet, h.s., to t.i.d. dosage

Roche® LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

Public Enema No. 1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU

ORGANIZATION SECTION

Governor Nunn To Deliver Keynote Address At Opening Session Of 1969 KMA Interim Meeting March 26-27 in Lexington

The Honorable Louie B. Nunn, governor of Kentucky, will be the keynote speaker at the opening session of the 1969 KMA Interim Meeting March 26-27 at the Continental Inn, Lexington.



Governor Nunn



Doctor Dunlop

Governor Nunn, director of the Health Planning Commission, will discuss aspects of Comprehensive Health Planning in Kentucky. This topic will receive major emphasis during the meeting and serve as the theme of a panel discussion on March 27 moderated by George F. Brockman, M.D., Greenville, KMA past president.

Members of the panel will include Frederick A. Stine, M.D., Ft. Thomas, member of the State Health Planning Council; Frank J. Groschelle, administrator of the Kentucky Program Development Office; Strawn W. Taylor, state director of Comprehensive Health Planning; and Senator Clyde Middleton, Covington, from Kentucky's 24th District, and chairman of the state Comprehensive Health Planning Council.

Thursday morning's program will also feature a discussion of Health Manpower. The names of the local and national speakers to participate in this portion of the program will be released in the February issue of *The Journal.*

George R. Dunlop, M.D., Worcester, Mass., president of the Massachusetts Blue Shield Plans, will deliver the luncheon address March 27 at the close of the meeting. Doctor Dunlop's topic will be "Blue Shield's Partnership with Medicine."

A 1931 graduate of Harvard Medical School, Doctor Dunlop is a member of the Board of the National Association of Blue Shield Plans, the Governor's Medical Advisory Council for Medicaid, and numerous medical and civic societies and organizations.

In addition to the outstanding program planned for the two-day session, there will be a meeting of the KMA Board of Trustees, an Orientation Program for new KMA members, and a meeting of the Woman's Auxiliary to KMA.

Henry B. Asman, M.D., KMA president, urges all Kentucky physicians to make plans now to attend the Interim Meeting and to secure reservations at the Continental Inn at an early date.

First Trustee District To Meet January 22 in Paducah

The First Trustee District of the Kentucky Medical Association will hold its annual dinner meeting at 6:00 p.m., January 22, at the Paducah Country Club, according to C. C. Lowry, M.D., Murray, district trustee.

Henry B. Asman, M.D., Louisville, KMA president, will be the featured speaker on the program. John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board, will appear on the program with Doctor Asman.

All physicians and their wives in the First District are invited to attend the meeting, hosted by the McCracken County Medical Society, Doctor Lowry said.

U of L Oral Cancer Symposium To Be Presented February 8

The Fifth Oral Cancer Symposium will be presented by the Oral Cancer Diagnostic Program of the University of Louisville at 8:45 a.m. February 8 in the General Hospital Rankin Amphitheatre, Louisville.

The theme of the symposium will be "Rehabilitation of the Head and Neck Cancer Patient." Some of the program participants and their topics will be:

"Oral Cancer Programs," Richard Hayes, D.D.S., U.S. Public Health Service; "Newer Developments in Maxillofacial Prosthetics," Victor Matalon, D.D.S., Houston, Texas; "Intra-Oral Prosthetics after Cancer Treatment," Kenneth Adisman, D.D.S., New York, N.Y.; "Mandibular Implants after Resection,"

Varoujan Chalian, D.D.S., Indianapolis, Ind.; "Role of Rehabilitation Centers," Robert Smith, M.D., Louisville; "Restoration of Swallowing Mechanism and Plastic Surgical Problems," Donald Shedd, M.D., Buffalo, N.Y.; "Speech Rehabilitation," James Shanks, D.D.S., Indianapolis, Ind.; "Esophageal Speech," Hazel Waldron, Louisville; and "Functional Restoration after Radiation Therapy," Ralph Scott, M.D., Louisville.

Marvin Barnett, D.M.D., Louisville, will moderate a panel discussion of "Maxillofacial Prosthetics," during the symposium. All physicians, dentists, medical students and dental students are invited to attend.

ACS Sectional Meeting To Be In Louisville Feb. 24-26

More than 550 surgeons are expected to attend a sectional meeting of the American College of Surgeons February 24-26 at the Brown Hotel, Louisville, according to James C. Drye, M.D., Louisville, chairman of the local advisory committee on arrangements.

Highlights of the three-day session will include "How-I-Do-It" clinics, panel discussions, symposia, scientific papers and films. Preston A. Wade, M.D., New York, N.Y., president of the College, will preside at the opening session on "Day to Day Transportation and Management of the Injured—Louisville Plan for the Care of the Injured."

Kentucky fellows of the College assisting Doctor Drye with arrangements include Douglas M. Haynes, M.D.; Thomas M. Marshall, M.D.; Roderick MacDonald, M.D.; George I. Uhde, M.D.; Owen B. Murphy, M.D.; Harry D. Stambaugh, M.D.; John S. Herter, M.D.; Robert Lich, M.D.; Rudolf J. Noer, M.D.; and Allan M. Lansing, M.D., Louisville; Loren J. Humphrey, M.D. and David A. Hull, M.D., Lexington; Robert W. Robertson, M.D., Paducah; Clyde C. Sparks, M.D., Ashland; Richard E. Grise, M.D., Bowling Green; William T. McElhinney, M.D., Covington; and James E. Hix, M.D., Owensboro.

AMA House Acts on 94 Matters During Clinical Convention*

Discrimination in American Medical Association membership because of color, creed, race, religion or ethnic origin is clearly prohibited by a section added to the Association's bylaws by the House of Delegates at the 22nd Clinical Convention, December 1-4 in Miami Beach, Fla.

A second amendment adopted in the bylaws provides a mechanism for implementing the prohibition in case of repeated violations.

In other, equally far-reaching actions, the House directed the Council on Constitution and Bylaws to prepare "appropriate Bylaw amendments so that qualified Doctors of Osteopathy may be admitted to full active membership in the American Medical Association" and adopted a Board of Trustees report providing a number of significant avenues whereby "qualified osteopaths may be assimilated into the mainstream of medicine."

Those were only two of the forward steps taken by the AMA House of Delegates during 10 hours and 47 minutes of deliberations in convention at Miami Beach.

Attendance at the House session went from a low of 91% at the opening meeting (223 out of 242 delegates present) to a high of 99% (240 delegates) at the Tuesday and Wednesday sessions when actions were taken.

Ninety-four items of business were brought to the attention of the House, including 22 reports from the Board of Trustees; one from the Joint Conference Committee of AMA and Blue Shield; four from the Council on Medical Service; three from the Council on Medical Education; two from the Council on Constitution and Bylaws; and 62 resolutions from state medical associations, scientific sections and individual delegates.

Of the 32 reports, 18 were adopted; three were amended and adopted; eight were accepted for information; one was amended and then accepted for information; one was approved; and one was rejected. (The House did not pass the Constitutional and bylaw amendments that would have enlarged the Board of Trustees to 16 members by giving the Vice President a vote on the Board.)

Of the 62 resolutions, 12 were adopted; 19 were amended and adopted; six were combined with one or more others into substitute resolutions; three were absorbed into other adopted resolutions; six were referred to the Board or a Council; five were rejected; six were replaced by substitute resolutions; three were replaced by substitute resolutions which were then amended; and two were withdrawn before being sent to a Reference Committee.

This report received from the office of the Acting Executive Vice President, AMA

AAPHP Honors Dr. Teague

Russell E. Teague, M.D., Frankfort, Commissioner of Health for Kentucky during the past 13 years, received the Distinguished Service Medal from the American Association of Public Health Physicians during its recent annual meeting in Detroit, Mich.

Ky. Physician Attendance High At Annual SMA Convention

Ninety-eight Kentucky physicians attended the 62nd Annual Meeting of the Southern Medical Association November 18-21, according to the daily registration bulletins published during the convention. More than 3,000 physicians attended the meeting at Rivergate Exhibition Center in New Orleans, La.

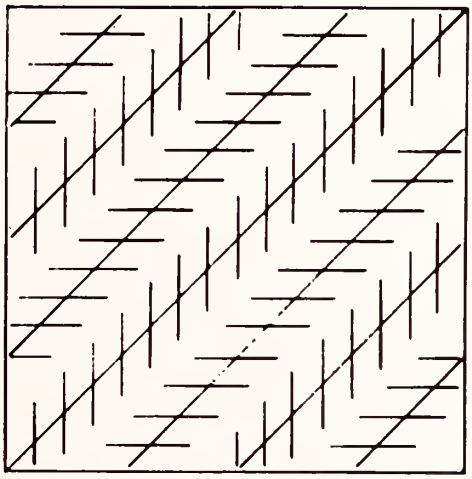
Highlights of the convention included presentations and discussions in 21 areas of medical specialties, professional and technical exhibits, and the President's Luncheon featuring guest speaker William B. Walsh, M.D., president and medical director of Project Hope.

A complete list of Kentucky physicians attending the meeting appears on the next page.

Samuel M. Adams, M.D., London
Hugh P. Adkins, M.D., Louisville
Albert L. Allen, M.D., Winchester
John Ammon, M.D., Florence
Marion E. Arnold, M.D., Madisonville
James W. Bard, M.D., Lexington
Richard A. Blair, M.D., Paducah
C. M. Blanton, M.D., Paducah
James S. Brashear, M.D., Central City
Carl J. Brueggemann, M.D., Covington
Glenn W. Bryant, M.D., Louisville
R. Rhodes Burnam, M.D., Louisville
Woody G. Burrow, M.D., Paducah
E. Dean Canan, M.D., Louisville
Eugene A. Castle, M.D., Madisonville
Robert H. Cofield, M.D., Covington
William J. Colburn, M.D., Calvert City
R. C. Comstock, M.D., Louisville
S. L. Cooke, M.D., Harlan
Joseph Daugherty, M.D., Florence
Edwin T. Davis, M.D., Paducah
Henry F. DeLong, M.D., Louisville
E. E. DeVillez, M.D., Covington
E. T. Edwards, M.D., Louisville
Ollie B. Emerine, M.D., Elizabethtown
F. F. Ferguson, M.D., Madisonville
John B. Floyd, Jr., M.D., Lexington
William Gillespie, M.D., Louisville
J. D. Gordinier, M.D., Louisville
William J. Graul, M.D., Versailles
Dallas C. Hagg, M.D., Frankfort
C. Noel Hall, M.D., Versailles
Michael T. Hamilton, M.D., Louisville
J. Duffy Hancock, M.D., Louisville
Stuart E. Harlowe, M.D., Louisville
Henry Harris, M.D., Bowling Green
James C. Hart, M.D., Murray
Fred C. Hauck, M.D., Owensboro
William F. Hawn, M.D., Louisville
Arthur Hellebusch, M.D., Lexington
W. C. Hollingsworth, M.D., Ft. Knox
Harry E. Homan, M.D., Ashland
Alfred A. Jacobs, M.D., Erlanger
Robert B. Jasper, M.D., Somerset
W. R. Johnson, M.D., Paducah
David H. Johnston, M.D., Lexington
Raymond E. Jones, M.D., Louisville
Conrad Jones, M.D., Murray
Charles W. Justice, Jr., M.D., Ludlow
Martin P. Kaplan, M.D., Lexington
Esten S. Kimbel, M.D., Frankfort
Harold King, M.D., Benton
Wayne Kotcamp, M.D., Louisville
E. E. Landis, M.D., Louisville
W. W. Leavell, M.D., Lexington
C. C. Lowry, M.D., Murray
Carroll H. Luhr, Jr., M.D., Louisville
Robert J. McGrath, M.D., Louisville
William J. McNabb, M.D., Louisa
H. B. McWhorter, M.D., Ashland
Paul F. Maddox, M.D., Campton
Andrew M. Moore, M.D., Lexington
Horace A. Norrell, M.D., Lexington
Ethel H. O'Brien, M.D., Louisville
John S. Oldham, M.D., Owensboro
A. Evan Overstreet, M.D., Louisville
Sam A. Overstreet, M.D., Louisville
Joseph B. Parker, Jr., M.D., Lexington
C. Kenneth Peters, M.D., Louisville
F. M. Picklesimer, M.D., Paintsville
J. A. Poe, M.D., Fulton
William H. Powers, M.D., Louisville
Thomas Pruitt, M.D., Harlan
Lloyd F. Redick, M.D., Lexington
O. M. Richardson, M.D., Elizabethtown
Gradie Rowntree, M.D., Louisville
Marjorie Rowntree, M.D., Louisville
Benjamin F. Rush, M.D., Lexington
Allen M. Sakler, M.D., Louisville
Marlyn M. Sanders, M.D., Owensboro
R. J. Sanders, M.D., Owensboro
Merrill W. Schell, M.D., Owensboro
Frank K. Sewell, M.D., Mt. Sterling
J. Day Shanklin, M.D., Louisville
Charles J. Shipp, M.D., Greenville
William B. Simpson, M.D., Mayfield
Thomas G. Stigall, M.D., Louisville
Charles C. Smith, M.D., Louisville
Paul R. Smith, M.D., London
Tom J. Smith, M.D., Louisville
Dixie E. Snider, M.D., Springfield
Charles Tarkington, M.D., Lexington
M. C. Veal, M.D., Henderson
D. Vertrees, M.D., Georgetown
Gene T. Watts, M.D., Hindman
Bernard Weisskopf, M.D., Louisville
Roger K. White, M.D., Louisville
A. C. Wright, M.D., Cynthiana

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

KNOW YOUR CONGRESSMEN

Hoyt D. Gardner, M.D., Louisville, chairman for national affairs of the KMA Committee on Legislative Activities, urges all physicians to become acquainted with their congressmen and points out that the congressman is interested in having the views of his constituents.

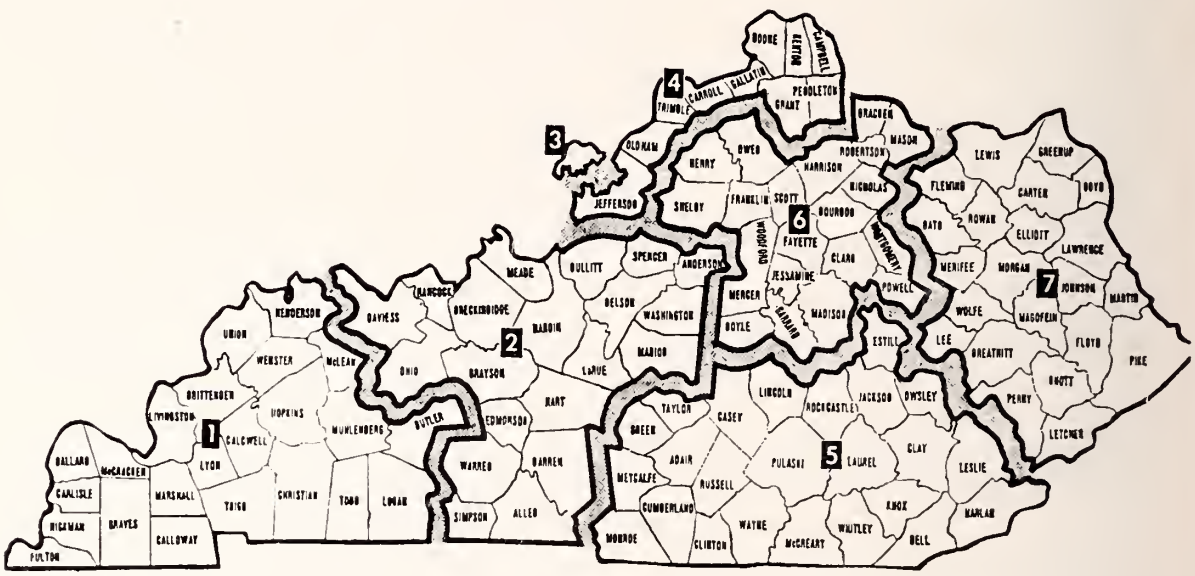
The Journal, in order to assist you in accomplishing this, gives the following information. You may want to remove this page and keep it in your files.

Your congressman may be reached by addressing him in Washington at the address below. The Washington, D.C. zip code for the senators is 20510; the zip code for the congressmen is 20515.

The salutation of a letter should be formal, as "Dear Congressman Stubblefield," unless you are a good friend. Then, "Dear Frank" is permissible.

In writing, the direct approach to the subject is preferred. Don't ramble.

If the action is favorable, follow-up with a "thank you" note. It will be appreciated.



Kentucky's Seven Congressional Districts

CONGRESSMEN

District	Congressmen	Address
1	Frank A. Stubblefield (D), Murray	Room 1514 Longworth House Office Bldg.
2	William H. Natcher (D), Bowling Green	Room 2333 Rayburn House Office Bldg.
3	William O. Cowger (R), Louisville	Room 239 Cannon House Office Bldg.
4	M. G. "Gene" Snyder (R), Louisville	Room 1532 Longworth House Office Bldg.
5	Tim Lee Carter, M.D. (R), Tompkinsville	Room 1231 Longworth House Office Bldg.
6	John C. Watts (D), Nicholasville	Room 2411 Rayburn House Office Bldg.
7	Carl D. Perkins (D), Hindman	Room 2252 Rayburn House Office Bldg.

SENATORS

Senator	Address
John Sherman Cooper (R), Somerset	Room 125 Old Senate Office Building
Marlow W. Cook (R), Louisville	Room 437 Old Senate Office Building

In Memoriam

JAMES O. PIERCE, M.D.
Beechmont
1907-1968

James O. Pierce, M.D., 61, area health officer with the TVA Paradise Steam Plant since 1960, died suddenly November 26 at his home in Beechmont. A 1931 graduate of the University of Tennessee College of Medicine, Doctor Pierce was a veteran of World War II and had served with the Veterans Administration Hospital.

W. REEVE HANSEN, M.D.
Louisville
1921-1968

W. Reeve Hansen, M.D., 47, a Louisville physician, died December 11 in his office. Death was attributed to a heart attack. Doctor Hansen graduated from the University of Louisville School of Medicine in 1945 and had practiced in Louisville since that time. He was a member of the American College of Physicians and the American College of Internists.

ERNEST G. SKAGGS, M.D.
Paintsville
1905-1968

Ernest G. Skaggs, M.D., 63, a Paintsville surgeon since 1958, died November 15 at his home after a long illness. A 1933 graduate of the University of Tennessee College of Medicine, Doctor Skaggs practiced in Fleming for a number of years before moving to Paintsville. He was active in a number of medical and civic organizations.

MARCUS A. COYLE, M.D.
Springfield
1910-1968

Marcus A. Coyle, M.D., 58, a Springfield physician for 31 years, died December 8 at his home. Death was attributed to a heart attack. A 1938 graduate of the University of Louisville School of Medicine, Doctor Coyle was a medical examiner for the Washington County Selective Service Board and a member of numerous local civic organizations.

EMERGENCY ROOM PHYSICIAN

Accredited 280 bed progressive general hospital. Guaranteed annual income. Immediately available. Contact Administrator, Cabell Huntington Hospital, 1340 16th St., Huntington, West Virginia.

AMA

(Continued from page 58)

is not an investment house. The joining of the AMA, state medical association and county medical society is another service that the physician performs not only to his profession, or for the betterment of public health, but for himself. Many physicians do more in their contributions to these organizations, by serving on committees and councils and as officers.

But, let me say this: If all of the preceding information does not convince you of the effectiveness and dedication of AMA to the profession and the people of this country, let me ask you several favors.

1. Read with a critical eye, the newspapers and magazines of this country that mis-shape these statistics and misinterpret our work.

2. Don't quote your enemies, quote your friends.

3. Don't lend your voice to those who oppose medicine, thus adding credence to what they say. AMA and KMA aren't the ones passing the bills and controlling your practice.

4. Don't criticize AMA, county and state societies with inaccurate information, for this assists the enemies of medicine in eliminating the private practice of medicine and organized medicine as we know it today.

The oppostion knows we are divided. They are not.

PSYCHIATRIC RESIDENCIES FOR G.P.'s

NIMH residency training in approved three year program. Stipend $12,000 plus fringe benefits. Applicants must have completed four years or more of practice in field of medicine other than psychiatry and an approved internship. Applicants should not be over 45.

Address inquiries to:
Chairman
Department of Psychiatry
Medical College of Virginia
Richmond, Virginia 23219

Include curriculum vitae and recent photograph.

So he'll breathe easier: relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

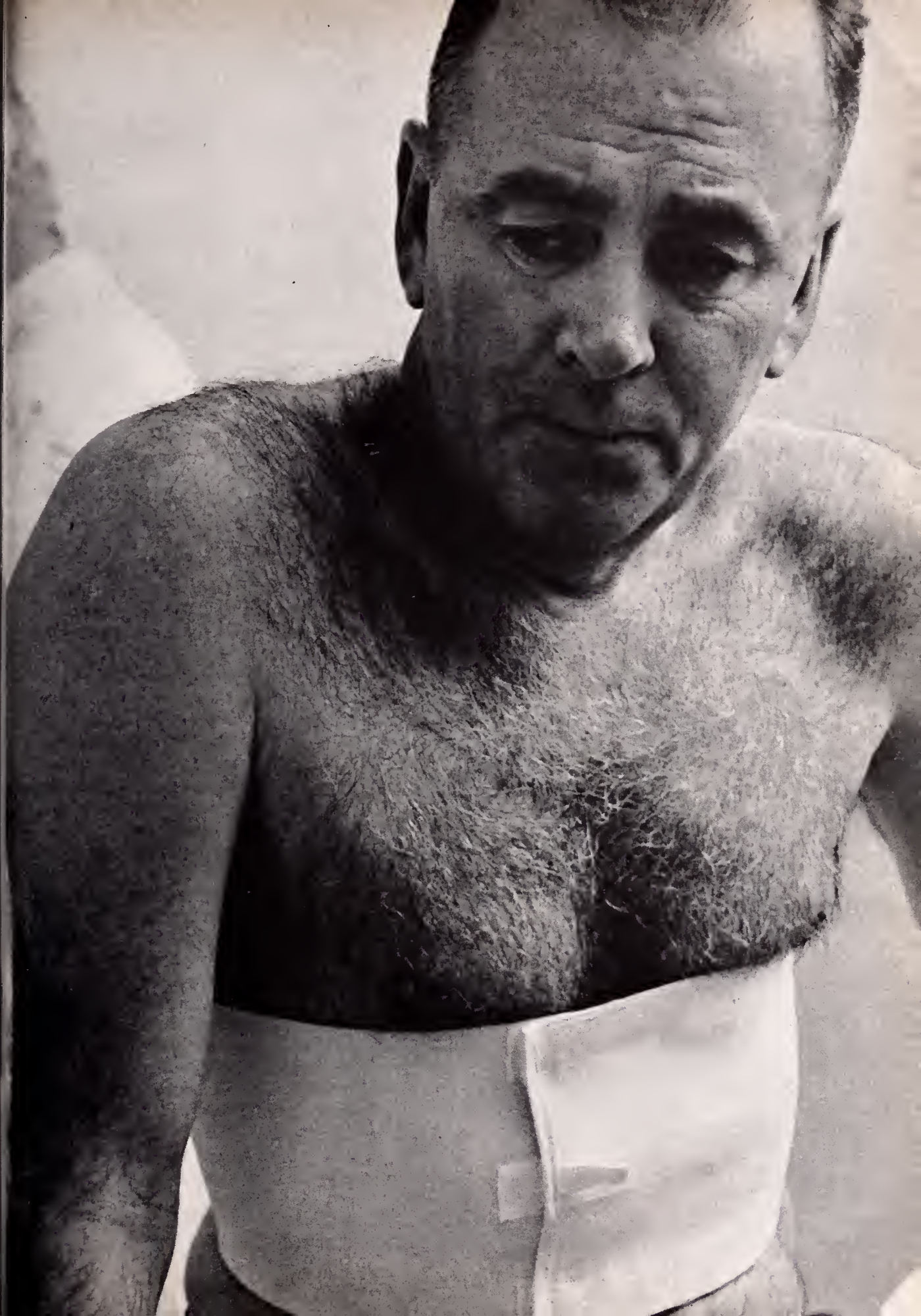
Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665.....President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660....Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123.....Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661.....Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211.....Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282.....Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552..Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340.....1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255.....1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362..1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231.....1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406.....1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751.....1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155....1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698.....1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357.....1969

Buyers Guide

JANUARY BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Cancer Society 16
Burroughs Wellcome 63
Cabell Huntington Hospital 71
Campbell Soup 47
Geigy Pharmaceuticals 18-20, 66
General Leasing Carporation 23
Glenbrook Laboratories 7
Highland Hospital 75
Hynson, Westcott & Dunning 3
King's Daughters Clinic 21
Lederle Laboratories 5, 25-26
Lilly, Eli & Company 32
Marion Laboratories 11-15
Medical College of Virginia 71
Medical Protective Company 75
Parke, Davis Company 27
Pitman-Moore Company 30-31
Poythress, Wm. P. Company 29
Rabins, A. H. Campany 8-9, 23, 50
Roche Laboratories 64-65, 76
Searle, G. D. & Company 48-49
Southern Optical Campany 69
Warner Chilcott 61-62
Winthrop Laboratories 28
Wyeth Laboratories 2, 51-52, 72-73

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-253-2761

Whenever anxiety induces or intensifies clinical symptoms

Librium®
(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination, on proper dosage~Has wide margin of safety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

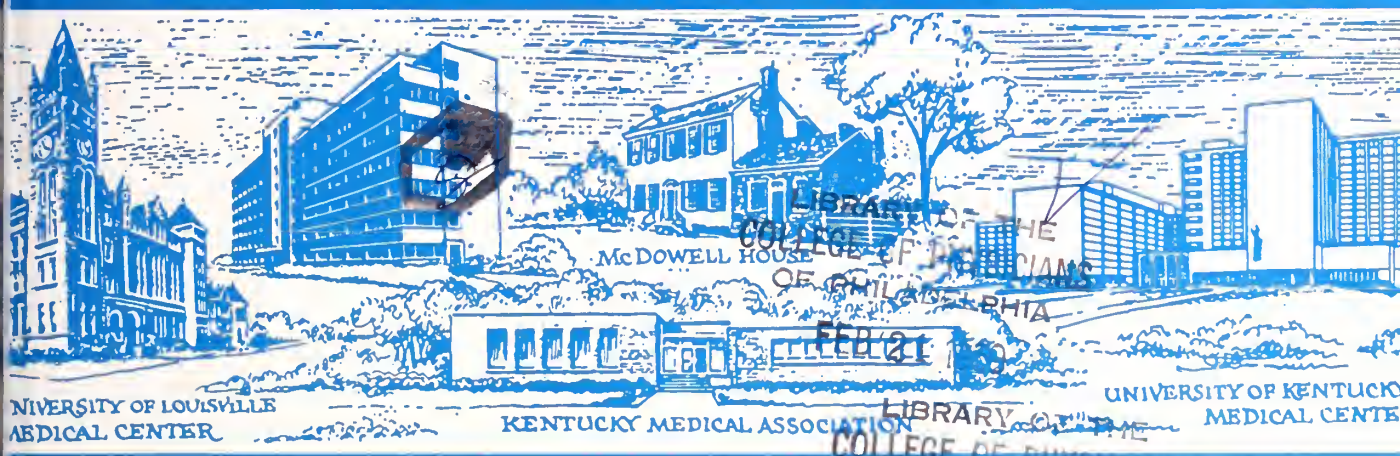
ROCHE

Roche®
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Also available: ***Libritabs***™ *(chlordiazepoxide) 5-mg, 10-mg, 25-mg tablet*

VOLUME 67 FEBRUARY 1969 NUMBER 2

The Journal of The KENTUCKY Medical Association



LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA FEB 21
LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA FEB 21

In This Issue

Extension of Medical Services through Nurse Assistants
W. B. Rogers Beasley, M.D., D.T.M., & H., M.P.H. 101

"Phlebitis" and Arithritis
Donald Wright, M.D., William P. Peak, M.D.,
Frank Lehn, M.D. and Mary Osborne, M.D. 107

Eventration through Umbilical Hernia During Pregnancy
E. Truman Mays, M.D. 110

Health Knowledge Among Residents Of A Rural Kentucky County
Emery A. Wilson, M.D. and Robert L. Kane, M.D. 113

Special Article

Usual and Customary Guidelines Approved
Roy Moore, Jr., M.D. 122

Complete Contents on page 80

KMA INTERIM MEETING
March 26-27
Continental Inn—Lexington

The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

Volume 67 • February 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Cae, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Peggy Roberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussions
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1971

McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970

Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D.
Roy A. Martin, M.D.
Charles R. Perry, M.D.
David C. Shipp, M.D.
John H. Willard, M.D.

Term Expires July 1, 1969

Paul E. Lett, M.D.
David A. Orrihood, M.D.
Harry A. Hamilton, Jr., M.D.
Leslie W. Blakey, M.D.
Raymond J. Timmermon, M.D.
William H. Gillespie, M.D.
J. J. Sonne, M.D.
John L. Creech, Jr., M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10.00—single copy 1.00
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Extension of Medical Services through Nurse Assistants
W. B. Rogers Beasley, M.D., D.T.M., & H., M.P.H. 101

"Phlebitis" and Arthritis
Donald Wright, M.D., William P. Peak, M.D., Frank Lehn, M.D. and Mary Osborne, M.D. 107

Eventration through Umbilical Hernia During Pregnancy
E. Truman Mays, M.D. 110

Health Knowledge Among Residents Of A Rural Kentucky County
Emery A. Wilson, M.D. and Robert L. Kane, M.D. 113

SPECIAL ARTICLES

Usual and Customary Guidelines Approved
Roy Moore, Jr., M.D. 122

EDITORIALS

Kentucky Medicine
Charles C. Smith, Jr., M.D. 126

Nurse!
Walter I. Hume, Jr., M.D. 127

Coquette
Hoyt D. Gardner, M.D. 128

SPECIAL FEATURES

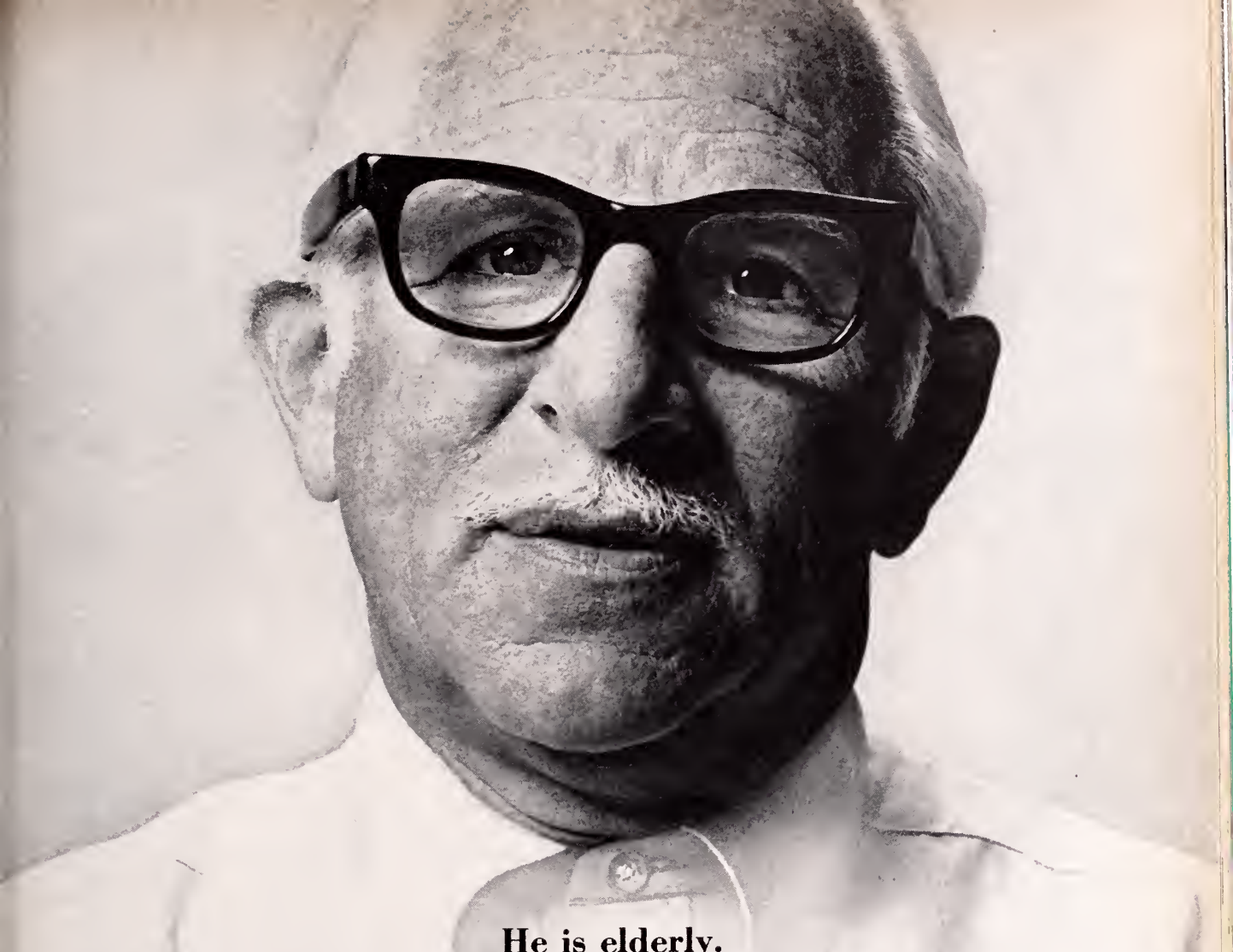
In Memoriam 129
1969 KMA Interim Meeting Program 133

ORGANIZATION SECTION

KMA Interim Meeting To Feature Discussions of Health Manpower, Comprehensive Health Planning March 26-27 in Lexington 132
KMA Awards Committee to Accept Nominations at Interim Meeting .. 132
New Member Orientation Course To Be Offered March 26 134
Senior Day Program To Feature Completely Redesigned Format 134
AMA Committee Appointments Include Eight Ky. Doctors 134
Lexington Clinic Conference Scheduled April 3 135
Heart Association Symposium Planned March 26-27 135
Digest of Board of Trustees Minutes December 11-12, 1968 136
Doctors, Wives Urged To Help in Project MED-AID: MARCO 136

REGULAR FEATURES

President's Page 82
Maternal Mortality Page 87
Blue Shield Page 90
Postgraduate Opportunities ... 94



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracy-

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES

MESSAGE FROM THE PRESIDENT



No Time To Relax

WITH a new Administration in Washington, and the promise of a "more conservative" Congress, it would be nice to look forward to a more favorable "atmosphere" in our Capitol. Many of us, however, overlook the fact that it frequently is not "the law" that gets you, but the regulations, and the bureaucrats who promulgate them, that do the damage.

Remember back during the 89th Congress, and before, when Medicine told Congress, and anyone else who would listen, that the proposed Medicare Law would (1) be inordinately expensive, (2) inevitably lead to the control of the practice of medicine, and (3) lead to demands that the program be expanded to cover everyone.

In the last few weeks, Mr. Cohen has complained of the cost of Medicare, indicated Congress might have to "set physicians' fees", and refused to raise the premium for Part B against the advice of his own actuaries, which must result in a huge deficit or . . . more reduction of reimbursement for services rendered.

Social Security Administration Secretary Robert Ball then held a meeting with the Part B intermediaries and stressed the program must operate within the program income, carriers must tighten up procedures in determining reasonable charges and in effect placed a ceiling on the upper limit of the range of reasonable charges. Along came the word also of the "Committee of 100" to promote compulsory health insurance for everyone in the United States with Walter Reuther as committee chairman and the eminent Michael DeBakey, M.D., as co-chairman.

There is no doubt that Medicare has increased the total cost of medical care for the general population. Hospital care accounts for the biggest part of that increase; physicians' fees contributed to a much lesser degree.

The physician has not been immune to the inflationary spiral; his cost-of-living went up 4.7% in 1968, just like everyone else's; his overhead went up; and his taxes went up 10% last April, right along with Mr. Cohen's. His patient-load also went up, as did his working hours, and his "paper work", both in his office and in the hospital—to satisfy the bureaucratic regulations sent down from Washington.

DON'T RELAX!

Henry B. Asman



A TRUSTED SYMBOL WHEN HEALTH CARE IS NEEDED

Kentucky BLUE SHIELD®[1] and BLUE CROSS,® trusted symbols in financing voluntary health care, offer you and your office staff *More Benefits* per *Dues Dollar* . . .

- Regardless of the number you employ
- In One Complete Package . . .
- At monthly group rates

BLUE SHIELD®[1] for surgical-medical services:
Schedule "C" - surgical allowances up to $270.
Schedule "D" - surgical allowances up to $405.
(These Blue Shield Schedules also provide allowances for In-Hospital Medical, X-Ray and Anesthesia Services.)
BLUE CROSS® for comprehensive hospital benefits:
With Semi-Private Room — PAID IN FULL.
All other COVERED hospital services are PAID IN FULL.
MAJOR MEDICAL PLAN
$100 Deductible
80% — 20% Co-insurance
$20,000 Maximum

If you are a physician practicing in Kentucky, age 64 or under, you and your employees are eligible for this Special Group Program.

Persons 65 or older may apply for the Blue Shield®[1] & Blue Cross ® 65 Plan.

For more information, CONTACT our office nearest you.

BLUE SHIELD®[1] & BLUE CROSS®

KENTUCKY PHYSICIANS MUTUAL, INC. • BLUE CROSS HOSPITAL PLAN, INC.

3101 Bardstown Road • Louisville, Ky. 40205 • (502) 452-1511

®[1] Registered service marks of the National Association of Blue Shield Plans
® Registered service marks of the American Hospital Association



Sometimes
he forgets he has hypertension, gets hot
under the collar...high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 8-67. A 33 year old, white, married, gravida 2 para 2 was seen in the emergency room at 3:20 p.m. on May 10, 1967, with a history of upper abdominal pain that later became generalized, together with nausea and vomiting of 16 hours' duration. Her last menstrual period, on April 19, was described as normal in all respects.

On initial examination, the blood pressure was 70/0, pulse 120. The patient was cold and clammy, and obviously in deep shock. A fluid wave was demonstrated in the lower abdomen and a boggy sensation was noted in the cul-de-sac. The impression was intra-abdominal bleeding.

The hemoglobin on admission was 9 grams, hematocrit 30, WBC 18,600. The urine contained a trace of sugar and 8-9 WBC/hpf.

An intra-catheter was inserted in the subclavian vein and the patient was typed and cross matched for blood. Meanwhile, 500 cc of Dextran was given, followed by 1000 cc saline; 500 cc of whole blood was then available and was administered. The pulse was now 70 and the blood pressure was 120/60. She was taken to the operating room where an exploratory laparotomy was performed and a small active bleeder was found on the right tube. There was approximately 2000 cc of blood in the peritoneal cavity. The right tube and ovary were removed, the blood was evacuated from the abdominal cavity, and the cavity was washed out with saline. The abdomen was then closed.

Because a repeat hemoglobin was reported on May 11 as 7 grams, she was given another 1000 cc of whole blood. There was a low-grade fever on May 12.

At 9:20 p.m., the patient suddenly became dyspneic. She had received a total fluid intake of 2500 cc on May 11 and 3000 cc on May 12, the latter including 500 cc of whole blood. She received a sedative and was seen by her physician at 10:45 p.m. She was cyanotic with a pulse rate of 160. There was blood-tinged sputum and bilateral rales in the lung bases. Oxygen was started, 50 mg of Heparin was given slowly intravenously and a consultant was called.

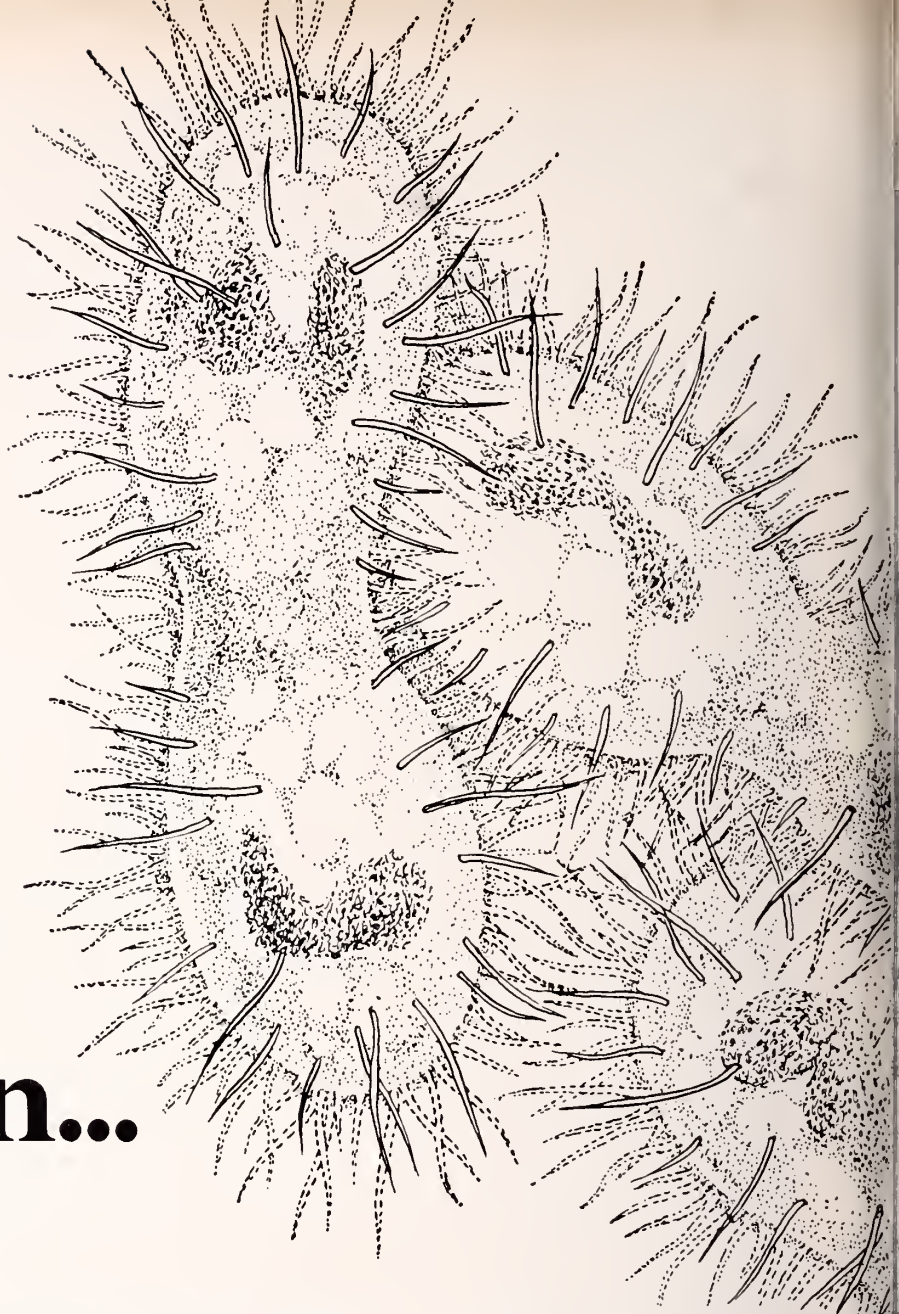
The patient appeared critically ill when the consultant arrived, and was described as cyanotic, dyspneic, and sitting upright in bed. There were no changes to percussion of her thorax; however, on auscultation, bronchial breathing was noted at the left base posteriorly, and in the mid-axillary line. No rales or rhonchi were present. Tactile fremitus was absent in the left base posteriorly. The heart showed sinus tachycardia, but no murmurs, and the pulmonary second sound was not accentuated. The impression was that of retained tracheobronchial secretions rather than pulmonary embolus, despite the fact that she had coughed up some blood-tinged material. She was taken to surgery where bronchoscopy was carried out with removal of viscous secretions from the tracheobronchial tree. This temporarily improved her condition and she was transferred to the intensive care unit. Soon, however, she again became dyspneic. Another bronchoscopy was done with removal of voluminous watery, pink-tinged secretions by almost continuous suction. She died with the bronchoscope in place, apparently from cardiac arrest.

At autopsy, the right lung weighed 930 grams, and the left, 900 grams. On section the cut surface of the lungs exuded a large amount of fluid and blood. The cut sections of the lungs floated heavily in the fixing solutions, sinking in some areas. The pulmonary arteries showed no emboli. Section through the tube showed the wall of the tube to be ruptured. The lumen contained numerous chorionic villi. In the wall there was invasion with trophoblast and inflammatory infiltration. The right ovary contained a corpus luteum of pregnancy.

The final diagnosis was 1) generalized pulmonary edema with beginning bronchopneumonia, 2) no histologic evidence for congestive atelectasis, and 3) recent abdominal surgery for ectopic pregnancy, right tube.

Comments

The Committee classified this case as a direct obstetric death with preventable factors on the part of the physician. It was the Committee's opinion that there was clinical evidence of pulmonary edema which was not treated as vigorously as possible at its first appearance; the autopsy findings suggested that pulmonary edema was significantly involved in the cause of death. Massive hemoperitoneum from any cause gives rise to complex problems of fluid balance, and in such cases circulatory overload is a serious hazard. This patient's chance for survival might have been increased if fluid replacement had been guided by central venous pressure monitoring.



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

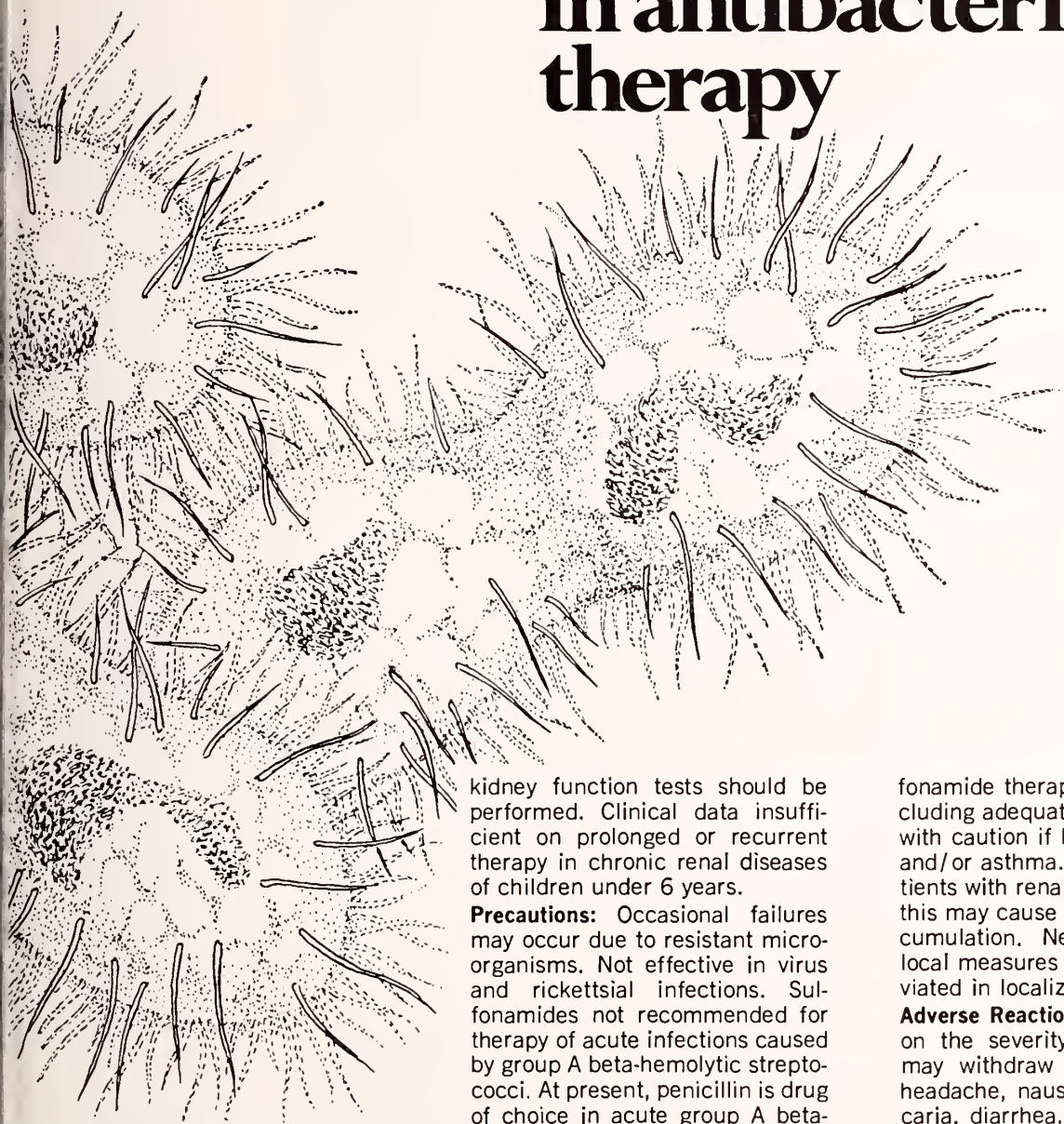
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for* fonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.



ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

Q. What Blue Shield contracts are administered on a Usual and Customary basis and how are they identified?

A. The Blue Shield Usual and Customary Program and the "High Option" Federal Employee Program are being administered using the Usual and Customary concept of the payment of physicians' fees in full for covered services. Allowances under Extended Benefits and Major Medical are based on a percentage of the physicians' Usual and Customary charge. Usual and Customary Blue Shield is identified by the Blue Shield coverage code 70 as indicated in the first 2 digits of the subscriber's Blue Cross and Blue Shield identification card.

Members having Extended Benefits or Major Medical are identified by the following codes listed under "Other" on the Blue Cross and Blue Shield identification card:

Extended Benefits	*Major Medical*
40 Single	*60 Single*
50 Family	*70 Family*

Members covered by the Federal Employee Program will have a special identification card. Effective January 1, 1969 members having the "High Option" Plan are covered by Usual and Customary benefits and are identified as follows:

Enrollment Code Number
101 High Option (Self Only)
102 High Option (Family)

The CHAMPUS Program (Civilian and Medical Program for Uniformed Services) is now being administered on the Usual and Customary basis; however, beneficiaries of this program have identification cards issued by the individual branches of the uniformed services.

Q. I have seen the terms "medical-economic area" and "90th Percentile" while reading recent articles about Usual and Customary. What do these terms mean?

A. Studies of physician charges indicate that different patterns of fees are charged by physicians depending on the location in which they practice. From these studies medical-economic areas were developed and ranges of fees organized representing all fees from the lowest to the highest, submitted by physicians for a given procedure.

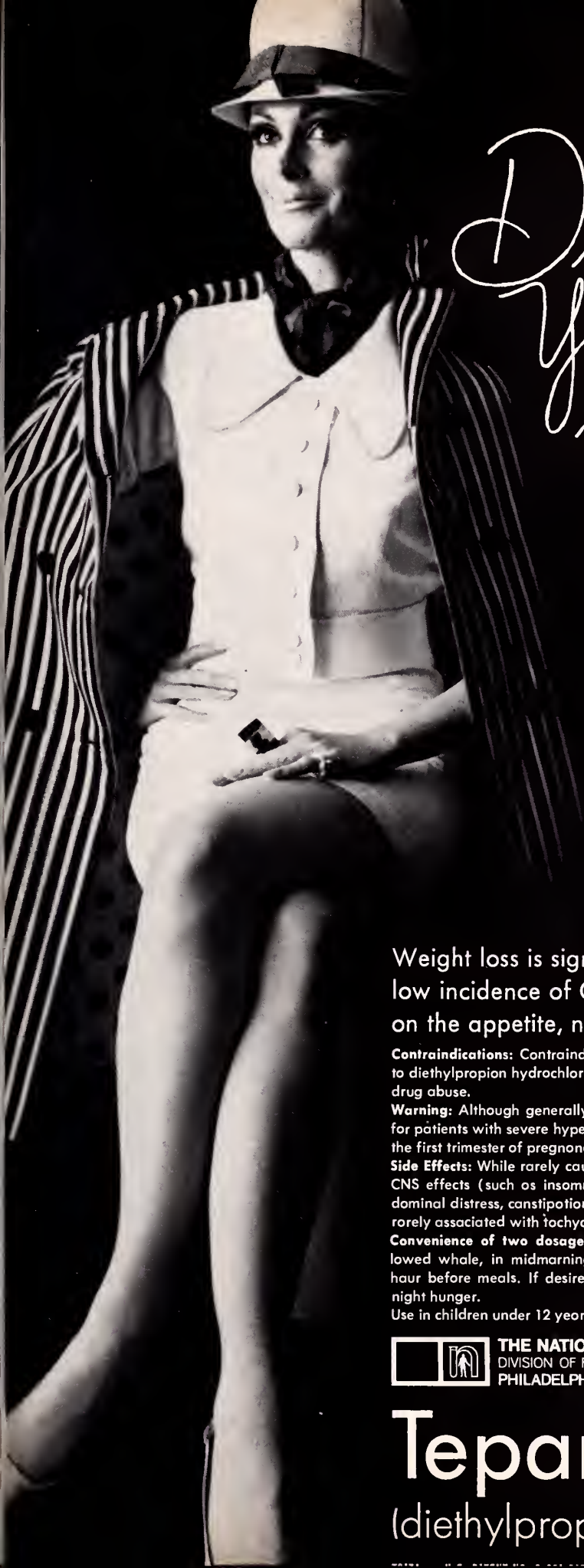
The 90th Percentile is that charge for a given procedure within the range that will pay in full at least 90 percent of all physicians' charges and at least 90 percent of all claims filed for a procedure. The 90th Percentile technique is used as the basic guideline for routine processing of claims under Blue Shield's Usual and Customary program.

Q. Will the guidelines for Blue Shield's Usual and Customary Program be re-evaluated to reflect the changes in physicians' charges?

A. This program maintains flexibility in that the medical-economic areas, the ranges and 90th percentiles are being continually revised based on actual charges of physicians as indicated on claims received by Blue Shield.

Q. Will the Usual and Customary 90th Percentile be available from Blue Shield?

A. The KMA Claims Review Committee, serving as a claim review mechanism and as an advisor to Blue Shield in the administration of its Usual and Customary Program, recommended that in order to protect the confidentiality of individual physicians' fees, the 90th Percentile not become general knowledge.



Dear Doctor,
You made me
what I am today -
a whole lot
slimmer!

TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicated concurrently with MAO inhibitors, in potients hypersensitive to diethylpropion hydrochloride, and in emotianally unstable patients known to be susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use greot coution when prescribing for patients with severe hypertension or severe cardiovoscular diseose. Should not be used during the first trimester of pregnoncy unless potential benefits outweigh potentiol risks.

Side Effects: While rarely causing therapy to be withdrawn, side effects may occur occasionally; CNS effects (such os insomnia, nervousness, jitteriness), dryness of mouth, thirst, nouseo, abdominal distress, canstipotion, headache, ollergic response including urticario or other dermatitis; rorely assaciated with tochycardio, cardioc arrhythmia or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab toblets: One 75 mg. toblet doily, swallowed whale, in midmarning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one haur before meals. If desired, on additional tablet may be given in midevening to overcome night hunger.

Use in children under 12 yeors of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

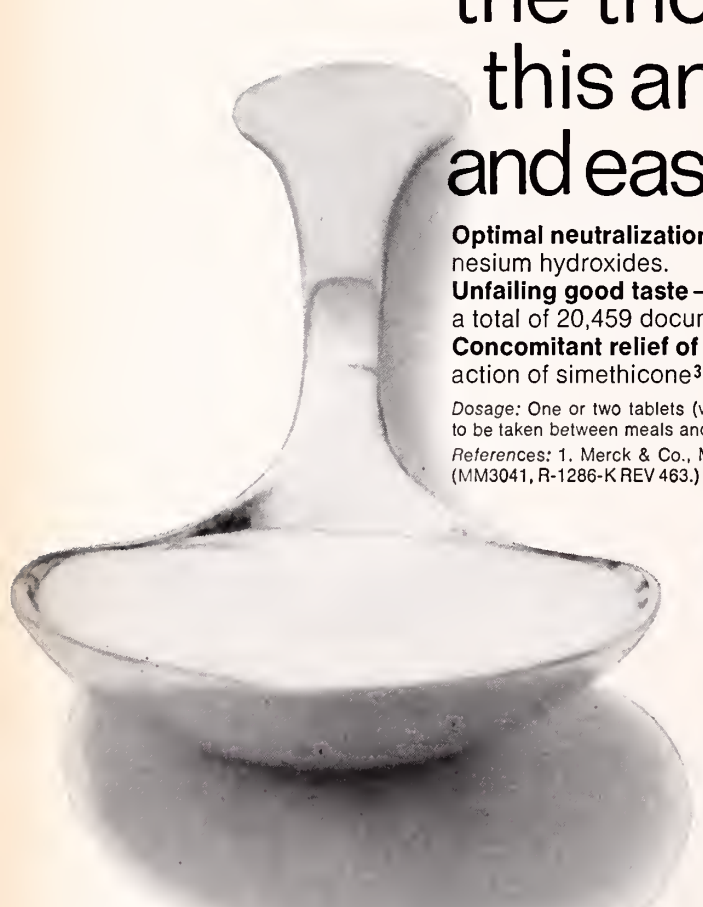
Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®

LIQUID/TABLETS

aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

PLAN TO ATTEND
Fifteenth Annual Symposium on Cardiovascular Diseases
March 26 and 27, 1969

BROWN HOTEL — LOUISVILLE, KENTUCKY

Wednesday, March 26, 1969
9:00 a.m.

"Reversible Forms of Hypertension and Their Management"

WALTER M. KIRKENDALL, M.D., Director, Cardiovascular Research Laboratories and of the Renal-Hypertension-Electrolyte Division, University of Iowa Hospitals, Iowa City, Iowa

"Hyperlipoproteinemia and Atherosclerosis"

PETER T. KUO, M.D., Associate Professor of Medicine, School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania

"Hemodynamic Effects of Cardiac Irregularities"

LOUIS N. KATZ, M.D., Director Emeritus, Cardiovascular Institute, Michael Reese Hospital and Medical Center, and Visiting Professor of Physiology, University of Chicago, Chicago, Illinois.

THE BERNARD D. ROSENBLUM MEMORIAL LECTURE

"Risk Factors in Coronary Heart Disease"

LOUIS N. KATZ, M.D.

"Exercise: Wishful Thinking or Wasteful Aching"

HENRY D. MCINTOSH, M.D., Professor of Medicine and Chief of the Cardiology Division, Duke University School of Medicine, Durham, North Carolina

"New Antihypertensive Drugs"

WALTER M. KIRKENDALL, M.D.

PANEL DISCUSSION

Thursday, March 27, 1969
8:30 - 9:30 a.m.

"Grand Rounds"

Louisville General Hospital, Rankin Amphitheater, Beverly T. Towery, M.D., Conducting Lecturer: A. Calhoun Witham, M.D.

Theme: "Cardiovascular Surgery and Related Topics"

10:00 a.m.

"Cardiac Valve Replacement"

ROBERT DREWS BLOODWELL, M.D., Chief of Pediatric Surgery Section and Assistant Professor of Surgery, Department of Surgery, Baylor University College of Medicine, Houston, Texas

"Surgical Treatment of Tumors of the Heart"

HENRY T. BAHNSON, M.D., Professor of Surgery and Chairman of the Department, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

"Clinical Aspects of Cardiovascular Anatomy"

A. CALHOUN WITHAM, M.D., Professor of Medicine and Chief, Division of Cardiology, Medical College of Georgia, Augusta, Georgia

"Human Cardiac Transplantation"

ROBERT DREWS BLOODWELL, M.D.

"Aortic Aneurysms—Complications and Treatment"

MYRON W. WHEAT, JR., M.D., Professor of Surgery and Chief, Division of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine, Gainesville, Florida

"Surgical Treatment of Thoracic Aortic Aneurysms"

HENRY T. BAHNSON, M.D.

PANEL DISCUSSION

REGISTRATION FREE

Sponsored by THE HEART ASSOCIATION OF LOUISVILLE AND JEFFERSON COUNTY, Inc., THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE and THE JEFFERSON COUNTY ACADEMY OF GENERAL PRACTICE and co-sponsored by THE COUNCIL ON CLINICAL CARDIOLOGY, AMERICAN HEART ASSOCIATION.

This program will be acceptable for eleven Prescribed hours by the American Academy of General Practice.

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

FEBRUARY

24-26 Kentucky Chapter, American College of Surgeons Sectional Meeting, Brown Hotel, Louisville

MARCH

20 Annual L. E. Smith Lecture, University of Louisville School of Medicine, Louisville

21-22 Kentucky Industrial Medical Association Spring Scientific Meeting, IBM Plant and Imperial House, Lexington

26-27 KMA INTERIM MEETING, "The Challenge We Face in 1969," Continental Inn, Lexington

26-27 Fifteenth Annual Symposium on Cardiovascular Diseases, Heart Association of Louisville and Jefferson County, Brown Hotel, Louisville

26-28 Continuing Education Course, "Some Neglected Aspects of Infection in Children," University of Kentucky College of Medicine, Lexington

28-29 Continuing Education Course, "Neoplastic Disease of the Urinary Tract," University of Kentucky College of Medicine, Lexington

APRIL

3 Fourteenth Annual Clinical Conference, Lexington Clinic, Lexington

10 Fifth Annual Rheumatic Disease Symposium, "What's New in Rheumatic Diseases," Rankin Amphitheater, Louisville General Hospital, Louisville

29-May 2 "Current Concepts in Bone and Joint Disease," Symposium, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

MARCH

5-6 Postgraduate Continuation Course, "Uro-Nephrology," Cleveland Clinic Educational Foundation, Cleveland, Ohio

13-15 American Electroencephalographic Society Course in "Current Problems in Electroencephalography: Advances Toward Their Solution," Houston, Texas

19 "Man and His Urban Environment" Colloquium, Losantiville Room, University of Cincinnati Tangeman Center, Cincinnati, Ohio

21-22 Twenty-second National Conference on Rural Health, American Medical Association, Philadelphia Marriott Motor Hotel, Philadelphia, Pa.

25-28 Center for the Study of Medical Education Workshop, "Instructional Skills for the Medical Teacher", University of Illinois College of Medicine, Chicago, Ill.

28-29 Third National Congress on "The Socio-Economics of Health Care," American Medical Association, Palmer House, Chicago, Ill.

APRIL

24-26 American Academy of Physical Medicine and Rehabilitation 31st Annual Session, Sheraton-Chicago Hotel, Chicago, Ill.

26-27 Twenty-first Annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology, University of Cincinnati College of Medicine, Cincinnati, Ohio

28-May 1 Seventeenth Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla.

MAY

8-10 National Conference on Breast Cancer, Shoreham Hotel, Washington, D.C.

14-16 National Society for the Prevention of Blindness, Inc., Annual Conference, Pfister Hotel, Milwaukee, Wisconsin



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

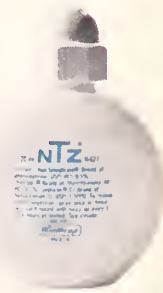
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

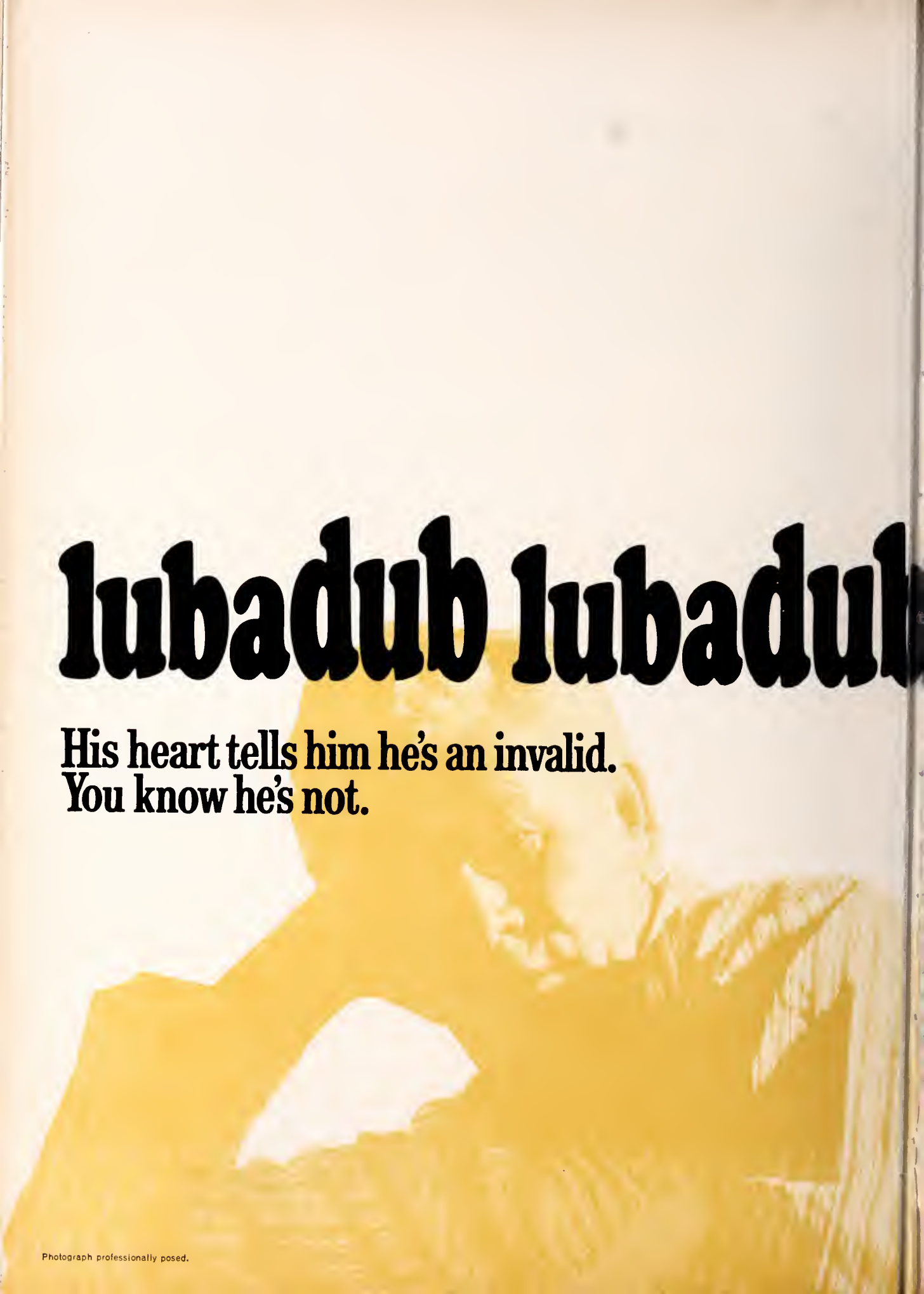
Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

lubadubdub lubadu

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

Equanil®

(meprobamate) Wyeth®



The two-stage power of the pink pill for U.R.I. symptoms is nothing to be sneezed at.

The immediate and continuous-release actions built into each Novahistine Singlet can give most of your patients prompt and long-lasting relief from symptoms of upper respiratory infection, including fever, aches and pains.
Not only does Novahistine Singlet provide a vasoconstrictor-antihistamine formulation to reduce congestion and help restore normal ciliary activity; it also contains an antipyretic-analgesic compound to relieve the fever, aches and pains that so frequently accompany upper respiratory infections.
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

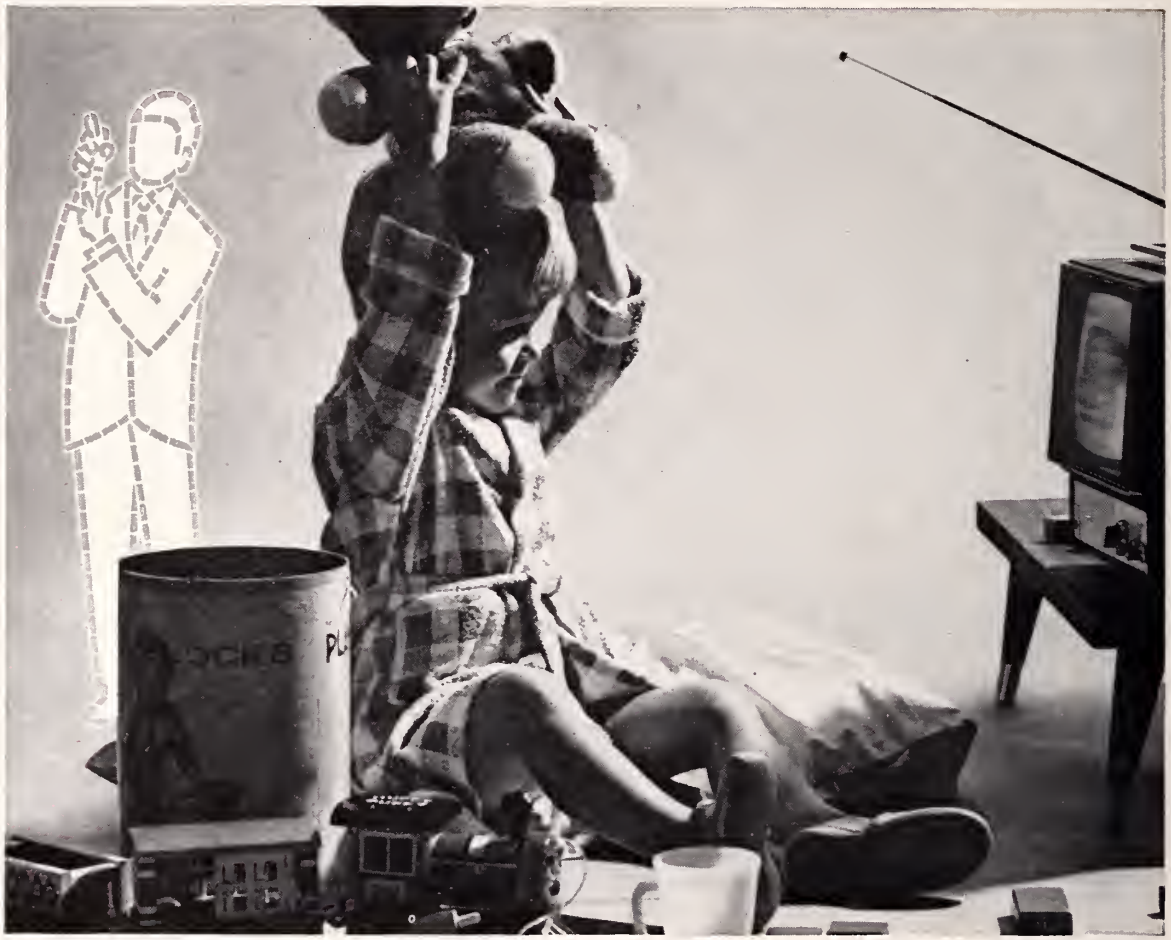
Pitman-Moore Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134 **Additional information available to physicians upon request.**

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 FEBRUARY, 1969 No. 2

Extension of Medical Services Through Nurse Assistants

W. B. ROGERS BEASLEY, M.D., D.T.M., & H., M.P.H.*

Baltimore, Maryland

The practice and potential for extending medical services through nurse assistants has been studied in relation to 48 specific procedures commonly used in the practice of medicine. This was done by means of a questionnaire sent to Appalachian physicians regarding attitudes toward nurse-assistants assuming more functions in patient care.

THE inability of physicians to adequately utilize rapidly proliferating medical knowledge because of the present static physician-population ratio has been the basis of much study.[1,2,3] Recommended solutions for this dilemma center on the re-distribution of responsibilities amongst the various levels of manpower delivering medical services.[4,5] Although there is emerging a plethora of new types of medical-hygienists and physician-assistants who have no previous clinical experience and who are trained for a particular purpose as single faceted practitioners, the more logical development is an expanded or upgraded nurse who develops through postgraduate training an area of special skill upon her base of general clinical nursing.[6,7,8,9,10]

Implementation of the recommended redistribution of responsibilities and functions will be governed by three factors:[11] (1) The desire and willingness of physicians to make such transfers to their nurses; (2) the willingness of nurses with supplemental training to assume the transferred responsibilities; and finally, (3) the acceptance by patients of the altered roles of these two familiar figures in medical care. Both of these professions are trained as members of a team which is directed by the physician and which functions within a university or institutional program. But institutions and physicians are rare in the socially deprived inner city or rural areas, thereby increasing the difficulties in the delivery of medical care.

Appalachia is such a deprived area where methods of improving medical services are being examined [12,13,14] and where the transfer of certain medical functions to nurses with specialized postgraduate training in nurse-midwifery has had a limited demonstration for 40 years.[15]

This paper reports a study in Appalachia of the attitudes and practices of physicians in transferring responsibility to their nurse-assistants. It briefly explores the congruency of the training nurses receive for certain job proce-

*Former medical director, Frontier Nursing Service, now with the Agency for International Development, American Embassy, New Delhi, India

dures in relation to the procedures physicians expect them to perform.

Materials and Methods

The eastern third of Kentucky, 32 Appalachian counties, had a population of 666,573 in 1961; there were 361 licensed physicians for this area in 1966, giving a physician population ratio of 1:1800 which was approximately one third the national ratio of 1:600.[16]

Physicians who had graduated from medical school before 1930, and had therefore completed more than 35 years in practice, were not included in this study. The remaining 308 active listed physicians were stratified according to (1) the size of their office community from the 1960 U.S. Census; (2) their main emphasis in practice or specialty as listed in the 1966 Directory of the American Medical Association, and (3) the availability of approved hospital beds as reported in the *1966 Guide Issue* of the *Journal of the American Hospital Association*. A 50% random sample was drawn from this stratification and 157 doctors identified. When a personal interview was attempted, it was found that 27 of these doctors (17%) had either died, retired, or moved from the 32 county study area. Of the remaining 130 physicians, 128 were available and interviewed, giving a 98% return from the sample.

A questionnaire was designed to identify the attitude and practice of each physician in transferring to his nurse-assistant 48 specific procedures. The procedures included secretarial, laboratory, and nurse's aide type of functions, as well as some customarily performed by professional nurses and by physicians. The questionnaire was designed by physicians experienced in rural medical problems, reviewed by nursing educators and practitioners, and pretested by Kentucky physicians.

To complete the questionnaire each physician was asked to reply in relation to the best office nurse he employed. (The education and training of the nurse was identified.) For each of the 48 procedures, the physician was asked:

"Does your nurse do this now?"

"If not, would you like for her to be trained to do it?"

"If not applicable to your practice, would you approve professionally of other physicians transferring this function to their nurses?"

These three types of answers were considered as approvals.

Disapprovals were recorded as "No nurse should ever do this", or when limitations were made on the nurse or the situation.

All interviews were carried out in either the office or the home of the physician.

Results

The distribution of the physicians in relation to the location of the general population, in relation to their special fields of interest, and in relation to their use of solo or group practice was basic to the attitudinal findings.

Although 81% of the population live in communities of less than 2,500 persons, only 24% of the physicians have offices there.

Group practice is claimed by 40% of the physicians; furthermore this technique is used at a significantly higher rate by the younger physicians.

General practitioners or family physicians make up 54% of the doctors, in contrast to the national level of 33%.

This family physician sees an average of 225 patients in his office each week. He makes an average of eight house calls per week and admits 10 patients to the hospital. Doubtless this heavy case load contributes to his significantly more favorable attitude toward the delegation of functions to his office nurse-assistant.

The procedures were grouped according to the functional areas of (1) History Taking and Record Keeping; (2) Physical Examination; (3) Active Therapy; (4) Treatment in the Absence of the Physician, and (5) Obstetrics. An average of 68% approval was given by the physicians for the transfer of these groups of procedures. The Physical Examination group had the lowest level of approval—51%—while History Taking and Record Keeping were approved by 86% of doctors. (See Table I)

Although 45% of physicians expect their nurses to take and record the preliminary medical history and to record the physician's treatment on the medical record, 19% disapproved of the nurse-assistant recording the treatment. It was felt by many that this might invalidate the medico-legal value of the record. (See Table II)

SUMMARY TABLE I
DISTRIBUTION OF PHYSICIANS' ATTITUDES TOWARDS THE DELEGATION OF PROCEDURES BY PHYSICIANS TO NURSES FOR THE CARE OF PATIENTS

Table No.	Procedures	Physicians' Replies (N = 128)	
		% Approval	% Disapproval
II	History Taking and Record Keeping	86	14
III	Physical Examination Procedures	51	49
IV	Active Therapy Procedure	80	20
V	Treatment in Absence of Physician	60	40
VI	Obstetrical Procedures	62	38

TABLE II
DISTRIBUTION OF PHYSICIANS' ATTITUDES TOWARDS THE TRANSFER OF HISTORY TAKING AND RECORD KEEPING PROCEDURES TO THEIR NURSE ASSISTANTS

Procedures	Physicians' Replies (N = 128)			
	% Approval			% Disapproval
	My Nurse Does This Now	Wish My Nurse Had Been Taught This	Approve Nurses Doing This for Others	Disapprove Nurses Doing This
Take and record preliminary medical histories	48	38	6	8
Record treatments on medical record	42	28*	11	19
Average	45	33	8	14

*A larger proportion of family doctors than specialists give this answer. (Chi. Square, p. < .05)

TABLE III
DISTRIBUTION OF PHYSICIANS' ATTITUDES TOWARDS THE TRANSFER OF PHYSICAL EXAMINATION PROCEDURES TO THEIR NURSE ASSISTANTS

Procedures	Physicians' Replies (N = 128)			
	% Approval			% Disapproval
	My Nurse Does This Now	Wish My Nurse Had Been Taught This	Approve Nurses Doing This for Others	Disapprove Nurses Doing This
Examine ears with otoscope	20	26	12	42
Examine throats	16	20	16	48
Insert speculum for Pap smears	14	24	34	28
Do Pap smears	7	33*	26	34
Examine the abdomen by palpation	7	24*	14	55
Listen to heart and lungs	5	11	6	78
Routine well baby examinations	2	21*	16	61
Average	10	23	18	49

* A larger proportion of family doctors than specialists give this answer. (Chi. Square, p. < .01)

The active approval (my nurse does this now) of physicians in transferring procedures in physical examination to their nurses is only 10%. But an average of 23% wish their nurses had been taught to do these procedures, with an almost equal level of professional toleration (18%) of other doctors allowing their nurses to do these procedures for them. The details of this table imply a high confidence in the screening ability of trained office nurses. (See Table III)

In examining the replies for the transfer of Active Therapy Procedures, more than 30% of the physicians expect their nurses to do these now, with the outstanding exception of "doing simple sutures". And here, although 6% of the nurses are asked to do this now, 27% of physicians wish their nurses were

TABLE IV
DISTRIBUTION OF PHYSICIANS' ATTITUDES TOWARDS THE TRANSFER OF ACTIVE THERAPY PROCEDURES TO THEIR NURSE ASSISTANTS

Procedures	Physicians' Replies (N = 1281)			
	% Approval			% Disapproval
	My Nurse Does This Now	Wish My Nurse Had Been Taught This	Approve Nurses Doing This for Others	Disapprove Nurses Doing This
Give intramuscular injections	85	7	4	4
Clean and dress wounds	75	11	6	8
Catheterize female patients	73	12	9	6
Give intravenous injections occasionally	45	17	15	23
Clean wax from external canal	33*	27	15	25
Do simple sutures	6*	27	13	54
Average	53	17	10	20

* A larger proportion of family doctors than specialists give this answer. (Chi. Square, $p < .011$)

TABLE V
DISTRIBUTION OF PHYSICIANS' ATTITUDES TOWARDS THE TRANSFER OF TREATMENT PROCEDURES IN ABSENCE OF PHYSICIAN TO THEIR NURSE ASSISTANTS

Procedures	Physicians' Replies (N = 128)			
	% Approval			% Disapproval
	My Nurse Does This Now	Wish My Nurse Had Been Taught This	Approve Nurses Doing This for Others	Disapprove Nurses Doing This
In physician's absence, give immunizations	48	10*	12	30
In physician's absence, give simple remedies	38	17*	14	32
In physician's absence, treat specific conditions on standing orders	24	9	9	59
Average	37	12	11	40

* A larger proportion of family doctors than specialists give this answer. (Chi Square, p. < .05).

TABLE VI
DISTRIBUTION OF PHYSICIANS' ATTITUDES TOWARDS THE TRANSFER OF OBSTETRICAL PROCEDURES TO THEIR NURSE ASSISTANTS

Procedures	Physicians' Replies (N = 128)			
	% Approval			% Disapproval
	My Nurse Does This Now	Wish My Nurse Had Been Taught This	Approve Nurses Doing This for Others	Disapprove Nurses Doing This
Do rectal exam in labor	25	23*	28	24
Check fetal heart tone	22	24*	28	26
Examine for fetal position	6	27*	21	46
Do follow up prenatal exam	6	21	22	51
Deliver a woman in normal labor	2	27*	26	45
Average	12	24	25	38

* A larger proportion of family doctors than specialists give this answer. (Chi Square, p. < .001).

trained for this procedure, while 54% disapproved of this specific transfer. (See Table IV)

Another facet of active therapy was identified as Treatment in the Absence of the Physician. This implies some independent judgment in assessing the patient's condition and administering a standard treatment in the absence of the physician, but a treatment according to his customary practices. Here, the 37% who do so now were balanced by the 40% of disapproving physicians, and the remaining 22% gave possible approval. (See Table V)

The five items examined under the Obstetrical Procedures indicate that while some critical procedures are not at present delegated to the nurse-assistant, an additional 24% of physicians wish more nurses were trained to do these items. This grouping is of perhaps greatest significance in that the profession of graduate nurse-midwives is an expanding one, not only in this deprived Appalachian area through the Frontier Nursing Service, but also in the metropolitan areas of New York and Baltimore, to mention but two. (See Table VI)

There was no significant difference in the attitude and practice of the physicians in delegating these procedures according to the training of the nurse assistant—whether B.Sc., R.N., or L.P.N.

Even though this assessment of physician approval is crude, it would appear adequate to encourage exploration in the expansion of nursing education for these and similar procedures.

A brief attempt was made to assess the relationship of nursing education to the performance of these functions. Three Diploma Schools of Nursing, three Baccalaureate Schools of Nursing and five Schools for Licensed Practical Nursing were asked to review the same questions presented to the physicians. In the Active Therapy, the Physical Diagnosis, and the Obstetric areas, more nurses were trained to do the procedure than were asked to do so by the doctors in offices. However, the training for History Taking was less adequate, and there was marked inadequacy of training for the Initiation of Therapy in the Absence of the Physician. The modestly conservative attitude of the physician for the transfer of functions is obvious in those areas where nurses are not fully utilized, and the persistent traditional pattern of nursing education is seen in other areas of judgment and procedure.

Conclusion

An increasing amount of independent judgment and consequent action is being required of office nurse assistants. Although the education and training provided students of general

nursing does not always equip them to perform the nursing services demanded in office practice, they do have certain areas of training which are not fully utilized at present. Both medical and nursing practitioners indicate an active desire for further transfer of responsibility to nurse assistants. Patient attitude has previously been demonstrated as an accepting one. Further expansion may best develop from the field of nurse-midwifery and pediatrics where this transfer is already successful.

Acknowledgement

The author is grateful to the physicians of east Kentucky, to the schools of professional nursing and to the schools of licensed practical nursing who so generously contributed time and experience to this study. A particular acknowledgement is due Doctors Alan Ross and Helen Abbey for their assistance in the sample design and to Doctor Kerr L. White for his support of the project.

This investigation was supported in part by the U.S. Public Health Service through Grant No. CH-00158 from the Division of Community Health Services and Contract No. HG.30,7003 from the Appalachian Regional Commission.

KEY WORDS: Appalachia
Kentucky
Medical manpower
Nurse assistant
General practice

Bibliography

1. National Advisory Commission on Health Manpower, 1967.
2. Fry, John, Administration and the General Practitioner, *Lancet,* Vol II, No. 7527: 1193-1195, (December 2) 1967.
3. Ad Hoc Committee on Education For Family Practice, *Meeting the Challenge of Family Practice,* p. 10, Chicago, American Medical Association, Council on Medical Education, 1966.
4. Pratt, H., The doctors view of the changing nurse-physician relationship, *J. Med. Educ.,* 40:8, 767-771, 1965.
5. Schlotfeldt, R. M., The nurse's view of the changing nurse-physician relationship, *J. Med. Educ.,* 40:8, 772-777, 1965.
6. Reiter, F., Nurse-clinician, *Amer. J. Nurs.,* 66:274-280, 1966.
7. Siegel, E., Dillehay, R., and Fitzgerald, C. J., Role changes within child health conference: Attitutdes and professional preparedness of public health nurses and physicians. *American J. Public Health,* 55:832-834, 1965.
8. Silver, H., Ford, L. C., Stearly, S. G., *A Program to increase care for children: the pediatric nurse practitioner program,* Paper presented at the 35th Annual Meeting of The American Academy of Pediatrics at Chicago, Illinois, October 24, 1966.
9. Hellman, L. M., O'Brian, F. J., Jr., Nurse-midwifery-an experiment in maternal care, *Obstet. Gynec.,* 24:343-349, 1964.
10. Reid, D. E., The obstetric and gynecologic discipline: potentials and responsibilities. *Obstet. Gynec.,* 17:263-268, 1961.
11. Connelly, J. P., Stoeckle, J. D., Lepper, E. S., and Farrisey, R. M., The physician and the nurse—their interprofessional work in office and hospital ambulatory settings, *New Eng. J. Med.,* 275:14, 765-769, 1966.
12. Kentucky, State Department of Health, Final Report, Community Health Services Project, CH. 19-6, A-64 *"Demonstration of Raising Health Levels in a Deprived Region",* Jan. 15, 1964—June 30, 1965. Submitted by: Russell E. Teague, Commissioner of Health (mimeographed).
13. Kentucky University, College of Medicine, Department of Community Medicine, Contract Report, *Health Status of the Population of Martin County,* Kentucky, 1964-1965—Jan. 15, 1966 (mimeographed).
14. Kentucky, State Department of Health, *Demonstration of Comprehensive Health Services for Leslie County, Kentucky.* Submitted to Leslie County Development Corporation, Hyden, Kentucky, Feb. 1, 1967, (mimeographed).
15. Beasley, W. B. R., The nurse-midwife as a mediator of contraception, *American Journal of Obstetrics and Gynecology,* 98:2, p. 201-207, May 15, 1967.
16. U. S. Bureau of the Census, *Statistical Abstract of the United States, 1962.* 83rd. Edition, p. 10, Washington, D.C. U. S. Government Printing Office. 1962.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

"Phlebitis" and Arthritis†

Donald Wright, M.D., William P. Peak, M.D.,

Frank Lehn, M.D., and Mary Osborne, M.D.

Louisville, Kentucky

Patients with rheumatoid arthritis and popliteal cyst commonly present a picture very similar to thrombo-phlebitis of the lower extremity. The etiology, diagnosis and therapy of this very treatable entity are herein discussed.

PATIENTS presenting with edema, tenderness, pain in the calf musculature on dorsiflexion of the foot (Homan's Sign), erythema and distention of superficial veins are usually considered to be suffering from a deep venous thrombophlebitis.[5] However, in the arthritides, especially rheumatoid arthritis, these symptoms may be indicative of a popliteal cyst (Baker's) rather than phlebitis.

These findings may be representative of a chronic dissection of a popliteal cyst into the musculature of the calf of the involved leg. Confusing the diagnosis even more is the acute dissection which commonly takes place.[5] It is not unusual for the patient to relate the acute onset to trauma, resulting at times in a diagnosis of "ruptured plantaris muscle".

Since the classical joint changes usually associated with rheumatoid arthritis may not be present in the patient, only a thorough history and physical including a complete joint examination will reveal the true diagnosis. The definitive diagnostic procedure will be discussed later. Bilateral popliteal cysts have been reported but this finding must be considered extremely unusual.

Although the possibility exists that both a deep venous thrombosis and a dissecting popliteal cyst may exist concomitantly, the occurrence in a patient with rheumatoid arthritis strongly points to the latter.[5]

†*Supported in part by the Kentucky Chapter, Arthritis Foundation. Reprints available from Frank W. Lehn, M.D., 315 Heyburn Bldg., Louisville, Ky. 40202*

Awareness of the manifestations of these two conditions is essential to avoid unnecessary surgery or to prevent the potential complications of anticoagulant therapy and prolonged hospitalization.

Case Reports

NUMBER ONE

A 43 year-old white male with a five year history of classical rheumatoid arthritis was admitted to the hospital with a complaint of "pain in the left knee". The pain, of acute onset, developed one week prior to admsssion while the patient was riding a bicycle. The pain developed in the superior aspect of the left gastrocnemius muscle and was followed shortly by edema in the popliteal area and superior aspect of the gastrocnemius. Physical examination revealed a swollen, painful, left leg with a mass-like lesion in the popliteal fossa. The lesion was thought by one observer to be a possible ruptured plantaris muscle. An arthrogram was obtained which revealed a cyst approximately 14 cm. X 6 cm. communicating with a smaller cyst in the fossa. (Figure 1)

NUMBER TWO

A 47 year-old white female, with a long history of rheumatoid arthritis primarily involving the knees, was admitted to the hospital complaining of pain and edema of the right calf. The onset of pain and edema was acute. Physical examination revealed an exquisitely tender and moderately edematous calf. An arthrogram revealed a large cyst in the popliteal space with extension into the superior aspect of the gastrocnemius muscle. (Figure 2)

The arthrograms performed in the above cases easily and quickly made the diagnosis. The technique for the procedure is as follows and should present no difficulty under usual circumstances.

FIGURE 1



FIGURE 2



The arthrogram should be performed with the patient on the x-ray table with film and technician ready. The necessary equipment includes a prep tray, local anesthetic, intra-articular corticosteroid, elastic bandage and 50 percent Hypaque. First, wrap the extremity from the ankle up to the knee with an elastic bandage in order to put the calf-dissection portion of the popliteal cyst under pressure. Then, leaving the medial side of the knee joint uncovered, wrap a second elastic bandage about the knee in a "figure-of-eight" fashion to direct the force of pressure distally. Then, exercising sterile technique, prep and drape the area for needle puncture which should enter one to two centimeters posterior to the medial aspect of the mid-patella. Withdraw only a few cc's of fluid, leaving the bulk of the fluid in the joint, and instill 15 cc. Hypaque with a steady deliberate force. Disengage the dye syringe, engage the corticosteroid syringe, inject one to two cc's into the joint space and remove needle. Next, have the patient flex and fully extend his knee several times and then x-ray the knee with both an AP and lateral view. If on viewing the film, dye is noted in cyst as well as in the joint, and dissection is demonstrated, remove the elastic bandage and passively move the knee through the full range of motion several times. If however, the dye is shown only in the joint with no cyst demonstrated, have the patient ambulate 25 to 50 feet and re-x-ray; remove the elastic bandage, repeat the ambulation and if the second films still have not demonstrated the cyst, repeat the x-ray. Patients should be encouraged to have no weight-bearing activities (not mandatory), for 24 to 48 hours after the procedure. The operative site should remain dry for three days.

There is occasional pain, although generally mild and brief, associated with the Hypaque injection.

As with all arthrocenteses, of course, synovial fluid analysis should be performed. Ordinarily, unless dissection and or rupture of the cyst has occurred, the above described procedure gives complete relief of both signs and symptoms. We feel that if a recurrence of the cyst takes place, surgical removal (often with knee synovectomy as well) is indicated.

Discussion

Popliteal cysts over the years have been known by a number of names such as: Baker's cyst, posterior herniation of the knee joint, synovial cyst, semimembranous bursae, gastrocnemius-semimembranous bursae and popliteal bursitis.[2] The condition was first described by Adams in 1840, who appropriately referred to it as "dropsy of the knee".[4,3]

The anatomy of the bursae of the popliteal area varies in description in the textbooks. This is probably due to the fact that one or more bursae are frequently fused. This has been demonstrated in cadaver dissections by Wilson, Eyre-Brook and Francis.[4]

The two most frequent structures suggested as sources for the popliteal cysts are (1) The posterior joint capsule and (2) bursae normally present in the popliteal space. Although some sources feel that the cysts of bursal origin predominate, it is our feeling that the most probable source is the posterior joint capsule. The pathogenesis is considered to be an increased amount of synovial fluid in the joint secondary to the rheumatoid process. The fluid may then be forced into the bursae, if communication exists or if posterior herniation ensues.[4] The increased intra-articular pressure may be simply the increased pressure of the joint fluid, or, as is frequently the case, increased fluid pressure secondary to sudden trauma. This may result in herniation of the posterior joint capsule with a release of fluid into the bursa in contact.

After this sequence of events the cystic mass is then susceptible to repeated irritation during movement of the knee and a chronic inflammatory process is initiated. Since fusion and communication do exist between the bursae, the process is propagated to the point of rupture with release of fluid into the superior aspect of the gastrocnemius muscle and frequently into the distal anterior aspect of the thigh. When this occurs, the clinical picture simulation thrombophlebitis develops.

Some workers have associated popliteal cysts, otherwise asymptomatic, with edema of the leg and foot. They postulate that the popliteal vein, medial distally, crosses over the artery in the popliteal space, and is subject to compression between a popliteal cyst and the artery.[2] Thus, venous compression by an asymptomatic cyst may account for dependent leg edema in patients with known rheumatoid arthritis or in patients with undiagnosed rheumatoid arthritis.

A positive Homan's sign is not always present. One report notes a negative Homan's sign in three out of five instances.[1] Successful aspiration of joint fluid from the calf made the diagnosis of ruptured popliteal cyst. The escape of rheumatoid synovial fluid into the tissue planes causes a widespread, painful, inflammatory edema which results so many times in the false diagnostic impression of phlebitis.

Summary

Two cases of ruptured popliteal cysts secondary to the rheumatoid process have been presented. In each case the signs and symptoms were compatible with the diagnosis of phlebitis, but arthrography substantiated the dictum that when "phlebitis" occurs in rheumatoid arthritis, suspect popliteal cyst! The definitive diagnostic procedure, the arthrogram, is described and its utilization encouraged in cases of popliteal cysts.

Bibliography

1. Dixon, Allan St. J., Acute Synovial Rupture in Rheumatoid Arthritis, *The Lancet*, Vol. 1, April 4, 1964, p. 743.
2. Good, Armin E., Rheumatoid Arthritis, Bakers Cyst and Thrombophlebitis, *Arthritis and Rheumatism*, Vol. 7, No. 1, Feb., 1964, p. 56.
3. Litwin, et. al., Bilateral Popliteal Cysts in a Patient with Rheumatoid Arthritis, *New York State Journal of Medicine*, Vol. 64, No. 16, Aug. 15, 1964, p. 2107.
4. Hoffman, Byron, Cystic Lesions of the Popliteal Space, *Surgery Gynecology and Obstetrics*, Vol. 116, No. 5, May 1963, p. 551.
5. Hench, P. Kohler, et. al., Dissecting Popliteal Cyst Simulating Thrombophlebitis. *Annals of Internal Medicine*, Vol. 64, No. 6, June 1966, p. 1259

Eventration through Umbilical Hernia During Pregnancy†

E. Truman Mays, M.D.*

Louisville, Kentucky

Evisceration through a spontaneously ruptured, infected umbilical hernia during premature gestation places the surgeon in a serious dilemma. Wound excision, reduction by tampon until term and laparotrachelotomy with simultaneous herniorrhaphy is recommended.

UMBILICAL hernias in children are rarely a problem and infrequently develop complications. In adults, however, complications of umbilical hernias are not uncommon and include incarceration of bowel or omentum with or without strangulation, spontaneous rupture and eventration. Pathologic or physiologic states producing sustained increases in intra-abdominal pressure are especially hazardous to adults with umbilical hernias. The intra-peritoneal pressure is transmitted to the hernial coverings and may progress to the point of seriously compromising the small nutrient vessels supplying the skin and peritoneum. The resulting ischemia may lead to skin necrosis and rupture, permitting the evisceration of transverse colon, omentum or small intestine.

The most common physiologic state producing increased intra-abdominal pressure is pregnancy. For this reason surgical teaching attests the importance of repairing umbilical hernias in pubertal females prior to their child bearing activity. Cirrhosis with ascites is perhaps the most common pathologic cause of increased intra-peritoneal pressure. Previous reports have emphasized the problem of ruptured umbilical hernias in cirrhotic patients with ascites.[1-3]

If a gravida experiences one of the above complications in a large umbilical hernia, the consulting surgeon is confronted with the dilemma of either interrupting the pregnancy, thus removing the cause of increased intra-abdominal pressure or, contrary to surgical teaching, attempting repair of the umbilical hernia ignoring the increasing intra-abdominal pressure. Should the patient be near term when the complication arises, the conceptus may be removed and primary herniorrhaphy accomplished without undue trepidation concerning the prognosis of either mother or child. If, however, the complication arises during a premature gestation, most clinicians would be extremely reluctant to remove the conceptus and subject the infant to the many hazards of prematurity.

The following case is reviewed because it illustrates the dilemma one faces when confronted with eventration through a large umbilical hernia during premature gestation. A plan of management is presented which takes into consideration the prognosis of the gestation, the welfare of the mother, and basic surgical principles regarding the accomplishment of a successful herniorrhaphy.

Case Report

A 20-year-old African, 28 weeks into her second graviditas, came from a distant village with several feet of small intestine protruding from the umbilicus. She was admitted at 12:15 a.m. on February 9, 1967. Five hours prior to admission the small intestine had extruded through a spontaneously ruptured umbilical hernia which had been present since childhood. Two weeks before this catastrophe she had noticed a sore in the tense skin overlying

†*From the department of surgery, University of Louisville School of Medicine, and the Baptist Medical Center, Ogbomosho, Nigeria*

**Assistant professor of surgery, University of Louisville School of Medicine, and former surgeon, Baptist Hospital, Ogbomosho, Nigeria*

the hernia. She was otherwise healthy. Uterine enlargement was compatible with seven months gravidity. Her oral temperature was 99.6°F; blood pressure 118/70mm. Hg.; pulse 86 per min.

In the operating room, under spinal anesthesia, after scrubbing the surrounding skin, the extruded intestine was irrigated with copious amounts of sterile physiologic saline. Sterile drapes were applied and the small bowel was manually returned to the peritoneal cavity. The defect in the skin was irregular and the edges were necrotic. There was a suppurative infection in the margins of the wound. The adjacent skin appeared ischemic for 4-5 millimeters beyond the open wound. The fascial defect measured 13 centimeters in diameter.

The infected and ischemic skin was widely excised and the wound closed primarily with interrupted 35 gauge stainless steel wire. No attempt was made to repair the large fascial defect. An ordinary surgical draping towel was irregularly formed into a bulky tampon and placed into the umbilical defect invaginating the skin into the peritoneal cavity. Adhesive strappings anchored the tampon in position.

The patient was discharged home on the fourth post-operative day. She was followed regularly as an out-patient and the tampon replaced at intervals. The wound healed by primary intention and the towel tampon relieved the tension on the skin and prevented subsequent pressure necrosis and eventration.

By this method reduction of the hernial sac was maintained until the gestation was 38 weeks. On April 14, 1967, she was readmitted and prepared for elective laparotrachelotomy. A healthy full term infant was delivered through a low transverse cervical cesarean section on April 17, 1967. After repair of the uterus, the original vertical midline abdominal incision was extended cephalad exposing the large umbilical hernia. The fascial edges were dissected and imbricated with interrupted far-near, near-far stainless steel sutures. The relaxed abdominal parietes facilitated a tension free fascial repair. The post-operative course was complicated by fever of 101°F. The fever subsided after 72 hours without recurrence. Antibiotics were administered. On the fifth post-operative day she was discharged.

After 12 months there was no evidence of recurrence of the hernia. The infant was healthy and developing normally.

Discussion

Spontaneous eventration is not a common complication of umbilical hernias. As early as 1858 Bontecou[4] reported a case of ruptured umbilical hernia with eventration followed by peritonitis and recovery. In 1918, McGrath[5] recorded the eventration of 15 feet of intestine through a ruptured umbilical hernia in a 78-year-old female. The catastrophe occurred while the patient was straining at stool. He replaced the intestines and repaired the defect on a kitchen table under ether analgesia. MacLean[6] (1950) operated on a three-month-old child who, during a severe bout of crying, ruptured an umbilical hernia and extruded three feet of small intestine. Helmig[7] (1958) reviewed the various kinds of ruptured hernias reported in medical literature. He found 16 cases of spontaneous eventration through a ruptured umbilical hernia, and concluded that this complication is more frequent in middle-aged and elderly patients with large hernias. Hardinger and Noskin[8] (1959) reported small bowel eventration through an umbilical hernia in a 71-year-old obese man. A primary herniorrhaphy was accomplished with uneventful convalescence.

Francis reported two patients who had only omentum protruding through spontaneously ruptured hernias. One was a 68-year-old male with massive ascites and the other a nephrotic, two-year-old female. The omentum was resected and routine umbilical herniorrhaphy performed in both of them. Rupnik and Brown[9] also described a patient with a ruptured umbilical hernia but only a tag of omentum protruding.

Eventration through an umbilical hernia during pregnancy is even more unusual and presents a unique problem in clinical medicine about which little is written. Glanville[10] reports the only other instance of eventration through an umbilical hernia in a premature gestation (28 weeks). His patient differed from the present case in that omentum alone protruded through the defect and the fascial opening was very small (0.5 cm.). He excised the tag of omentum and repaired the small hernia. The patient delivered spontaneously at home two months later.

The association of a premature gestation with ruptured umbilical hernia and evisceration of small intestine creates a serious dilemma. The increased intra-abdominal pressure secondary to a tense pregnant uterus prohibits primary operative repair of the hernia especially if it is a large defect such as encountered in the present patient. The basic surgical principle of accomplishing a tension free repair in herniorrhaphies is sound reason for intransigence in this situation. The insertion of synthetic mesh or a fascia lata graft as a prosthetic replacement would have been ludicrous in the presence of an already established suppurative infection. The removal of the conceptus by laparo-uterotomy could have resolved the problem of increased intra-peritoneal pressure and permitted the primary repair of the hernia without a prosthesis, but the hazards of prematurity thus forced on the infant makes this management untenable in most areas of the world.

The management used in this case was adopted by exclusion after considering the several possibilities. The large defect, increased intra-abdominal pressure and presence of suppuration in the wound precluded any attempt at primary herniorrhaphy either by imbrication or prosthetic replacement. The duration of the gestation, and the high mortality rate in premature infants, especially in developing countries of the world, prohibited cesarean section as a corrective measure for the increased intraperitoneal pressure which was the primary cause for skin necrosis and rupture. The wide surgical excision of the skin insured the removal of infected and ischemic tissue. But without repair of the hernia to protect the skin from future tension, the probability was great that pressure necrosis and subsequent rupture with eventration would occur again as the pregnancy progressed. The remaining choice was to tampon the umbilical defect, protect the skin from future pressure necrosis, and maintain the gravida to maturity.

When the pregnancy is full term two courses of management are feasible: (1) Allow labor to progress under close supervision, permitting spontaneous vaginal delivery followed by herniorrhaphy in the immediate postpartum period; or (2) Elective cesarean section and simultaneous repair of the hernia. It is more rational to choose the latter, reasoning that with even greater increases in intra-abdominal pressure during labor, a repeat rupture could occur presenting the miserable clinical situation of having several feet of intestine pushing through the umbilical defect and the patient in active labor.

The surgical towel tampon is an effective method of temporarily maintaining reduction in the large umbilical defects during pregnancy until term when the conceptus can be removed and herniorrhaphy performed. The lax abdominal walls after the uterus is emptied permits a tension free imbrication of fascia assuring an anatomically sound herniorrhaphy. The interposition of prosthetic materials is not usually necessary in even the large defects. The fact must be stressed that the towel tampon is only a temporary management and that surgical repair of the hernia should be the final goal in these patients.

The peritoneal contamination resulting from a singular rupture and eventration is not a serious problem. The peritoneum is a venerable organ. It endures tremendous insults extremely well. Bacterial contamination is usually resisted quite well even without the aid of modern antibiotics provided continued soilage and contamination are prevented. As illustrated by this patient who traveled several miles with her small intestine exposed to the hostile African milieu, a single insult is tolerated if repeated episodes of challenging trauma are avoided. When reasonable caution and mechanical cleansing are utilized, and care is taken not to overlook an intestinal perforation, recovery is in most instances uneventful. However, it is of utmost importance to prevent repeated peritoneal contamination. Eisenberg and Hoye (1960) report a case illustrating the serious consequences of failing to take aggressive steps to prevent persistent contamination of the peritoneum. Their patient, a 70-year-old cirrhotic, ruptured an umbilical hernia and drained ascitic fluid for several days before admission, which then continued for six days in the hospital. Surgical repair of the hernia was not done nor was any effort made to obtain temporary skin coverage thereby preventing repeated peritoneal contamination. Generalized fibrinous peritonitis observed at necropsy was thought to have precipitated the patient's demise.

The present case report and those reported by others emphasize several important clinical

(*Continued on page 148*)

Health Knowledge Among Residents Of A Rural Kentucky County†

EMERY A. WILSON, M.D.* and ROBERT L. KANE, M.D.**

Lexington, Kentucky

A random sample of persons living in a rural Kentucky county were interviewed by means of a multiple-choice health knowledge quiz. The correct response rate was approximately 53% which compares well with previous studies on urban populations.

ALTHOUGH the physician is responsible for diagnosing and treating illness, no treatment can be effected until the patient presents himself for care. The patient's role in initiating medical care has been well analysed;[1,2] one of the factors which will determine whether or not he seeks medical attention is his awareness of the symptoms of illness (or the need for routine examinations) and his recognition of the implications of these symptoms.

As part of his fourth year clerkship in community medicine, one of the authors (E. W.) interviewed randomly selected residents of a rural county to administer a health knowledge quiz. The purposes of this study were first, to assess the present level of knowledge of various diseases in a selected rural population and to study the factors which determine this knowledge; second, to provide an educational experience for the participants; and third, to obtain information for the use of the local medical personnel in future health planning.

Methods

A random selection of 100 households of a rural Kentucky county was accomplished using the utility company rosters. This method offered several advantages. The rosters provided an up-to-date list of at least 99% of the households in the county. These rosters were arranged by meter reader routes; it was therefore possible to perform cluster sampling along specific routes to facilitate interviewer travel. In addition, since the sample was based on geographic distribution, the location as well as the family name of each household selected was known.

A pre-coded multiple choice questionnaire was constructed and administered by a single interviewer to one subject in each household. The questions were designed to test basic health knowledge and attitudes. (See Figure 1) Preferably the subject was a female (mother or oldest daughter), the person felt to be most responsible for health care in the family. Where no female members of the household were available, males were interviewed. At the conclusion of the interview the respondent was given a summary of the correct answers with a brief explanation of each. The responses were recorded on optical scanning sheets for computer analysis.

A member of all 100 households included in the study sample was interviewed.* In general, if no one was found at home when the interviewer called, he made as many as 25 callbacks in order to obtain a complete sample.

Results

Eighty-five percent of those persons interviewed were female, including five non-white respondents. Eleven percent were under 20 years of age and an equal number were over 70. Only 37 percent had graduated from high

†*From the department of community medicine, University of Kentucky Medical Center*

**Intern, University of Kentucky Medical Center*

***Resident, University of Kentucky Medical Center*

**Four addresses were originally discarded when they proved to be institutions (schools, churches, offices, etc.) and are not included in this calculation.*

FIGURE 1

Examples of the Questions Used to Measure Health Knowledge

A "Pap" test is used to detect cancer in which part of the body?

a. Skin
b. Breast
c. Stomach
d. Cervix

Which of the following is the chiropractor best qualified to treat:

a. Heart Disease
b. Stomach Ulcers
c. Stiffness of Back or Joints
d. Headaches
e. All of the Above

Diabetes Mellitus (sugar diabetes)

a. Runs in the Family
b. Is Contagious
c. Is a Disease only of the Elderly
d. Is a Type of Cancer

Which of the following is *not* a possible cause of heart disease?

a. Cigarette Smoking
b. Excess Weight
c. Daily Exercise
d. Fatty Foods
e. High Blood Pressure

school. Thirty percent had a family income of less than $3,000.

No one answered all of the 27 questions on common diseases and health care correctly. The average number of correct responses was 14.4. There was no statistically significant correlation of correct responses and age or sex; however, there was a statistically significant correlation with level of education and family income. This may explain the significant difference in correct responses between whites and non-whites.

Respondents were also asked about the frequency of visits to their family doctors. Fifty-five percent stated that they saw them between zero and four times per year, while 13 percent had more than 12 visits. There was no statistically significant difference in the correctness of responses when compared by physician utilization.

When the interviewees were asked how far they lived from their family physicians, 25 percent said they lived within one mile and 80 percent within 10 miles of the doctors' offices. Again there was no significant difference in the number of correct responses by distance from physicians.

Several specific questions warrant special attention. Respondents could name an average of only 2.3 danger signals for cancer and only 1.9 warning symptoms of diabetes mellitus. No one could name all the warning symptoms for either disease. Twenty-one percent of the sample believed cancer to be absolutely incurable.

Discussion

It is difficult to compare the results here with previous studies since most of them were performed on patient populations. In a recent study of Eastern Kentucky patients discharged from a university hospital, the respondents demonstrated a knowledge of their diagnoses and a comprehension of the prescribed treatments well in excess of their physicians' expectations.[3] Seligmann et al. administered a similar multiple-choice health questionnaire covering 10 common diseases to medical clinic patients. The patients could correctly answer about 55 percent of the questions compared to the present study finding of 53 percent.[4] Interestingly, while the clinic physicians thought that the ordinary layman should know 82 percent of the facts covered, well over half the doctors polled under-estimated actual patient knowledge by at least 20 percent.[5]

Samora et al. administered the same health knowledge questionnaire to hospital patients and community residents in four different cities. The percent of correct responses ranged from 46 to 66.[6] As in the study presented here, the results correlated with socio-economic level (based on education and occupation). In general, the study sample did better on questions related to tuberculosis, diabetes and syphilis, in contrast to the poor responses of our study group to questions concerning the former two diseases.

In a study of medical vocabulary among hospital patients, these same investigators found that 19 percent of the respondents had no knowledge of 50 common medical terms; 23 percent of the responses were vague or wrong; and the remaining 58 percent represented correct explanations of the terms.[7]

Rosenstock has reviewed a model of health behavior with two basic classes of variables: the psychological state of readiness to take

(Continued on page 148)

now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



In childhood



Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

diarrheas...



- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. ½ tsp. 5 times daily (5 mg.)
2-5 yr. 1 tsp. t.i.d. (6 mg.)
5-8 yr. 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. **2.** Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. **3.** Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia 2:921-922 (Nov. 27) 1965. **4.** Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine



THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All five members of the Robitussin family contain glyceryl guaiacolate. This outstanding expectorant agent increases the output of lower respiratory tract fluid (R.T.F.) Increased R.T.F. volume thins mucus, thereby improving the action of bronchial and tracheal cilia and making thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"

ROBITUSSIN®

Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Alcohol, 3.5%	

For unproductive, allergic coughs

ROBITUSSIN A-C® (exempt narcotic)

Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.
(warning: may be habit forming)	
Alcohol, 3.5%	

Non-narcotic for 6-8 hour cough control

ROBITUSSIN-DM®

Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Dextromethorphan hydrobromide	15.0 mg.
Alcohol, 1.4%	

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS™

Each Cough Calmer contains:

Glyceryl guaiacolate	50 mg.
Dextromethorphan hydrobromide	7.5 mg.

Clears sinuses and nasal stuffiness as it relieves cough

ROBITUSSIN-PE®

Each 5 cc. contains:

Glyceryl guaiacolate	100 mg.
Phenylephrine hydrochloride	10.0 mg.
Alcohol, 1.4%	

	Robitussin	Robitussin A-C	Robitussin-DM	Cough Calmers	Robitussin-PE
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●	●	
Antihistamine		●			
Non-Narcotic	●		●	●	●
Long-Acting (6-8 Hours)			●	●	
Nasal, Sinus Decongestant					●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

SPECIAL ARTICLES

Usual and Customary Guidelines Approved

ROY MOORE, JR., M.D.*

IN IMPLEMENTING the resolution of the KMA Advisory Committee to Blue Shield, passed by the House of Delegates this past September, the Board of Trustees appointed the KMA Claims Review Committee. Our first concern was to establish guidelines for administering health care programs based on usual and customary fees. These guidelines have now been approved by the KMA Board of Trustees and are presented for the information of all concerned.

Being aware of the needs and demands for prepayment organizations to develop programs using the Usual and Customary concept, we must realize there is no program that can guarantee a physician that his fee will always be paid in full. There must be provisions for the predictability of costs in marketing such programs and for the professional review of cases that cannot be routinely processed.

Our House of Delegates recognized these factors when they adopted this resolution which re-affirmed support of the Usual and Customary principle and approved a mechanism of local peer review for cases that cannot be processed routinely. The resolution encourages all county medical societies with 20 or more active practicing physicians to establish a local review committee and counties with 10 to 20 members are invited to establish local committees. The resolution further provided for the establishment of the KMA Claims Review Committee, a central committee which represents all major specialty groups, including general practice to review cases from counties too small or counties that haven't established local review committees. The Committee will also review cases referred from local review committees on request by that committee, physicians, Blue Shield and third parties.

The Committee will be charged with the responsibility of recommending an allowance to be considered as payment in full. In addition, the Committee is to act in an advisory capacity to Blue Shield and third parties in the administration of the Usual and Customary Program.

Our first meeting was held on November 21, 1968, for the purpose of considering and approving the necessary guidelines and terminology for the implementation and administration of the Usual and Customary Program.

The definitions of Usual, Customary and Reasonable were approved as follows:

Usual—The "usual" fee is that fee usually charged for a given service by an individual physician to his private patient (i.e., his own usual fee).

Customary—A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area).

Reasonable—A fee is "reasonable" when it meets the definitions for both Usual and Customary, or in the opinion of the responsible medical association's review committee, is justifiable, considering the special circumstances of the particular case in question.

Several guidelines were established for the administration of the Usual and Customary Program. The Committee approved the use of medical-economic areas based on information from the KMA-Blue Shield Survey of physicians' fees conducted in 1967.

Statistics from the survey indicated that there are different patterns in the fees charged by physicians depending on the locations in which they practice. In each area, ranges of fees will be established for each procedure. The range represents all fees from the lowest to the highest submitted by physicians in a given area for the same procedure.

The 90th Percentile technique will be used as the basic guideline for making routine payment. The 90th Percentile is that charge within the range for a given procedure that will pay in full at least 90% of all physicians' charges and guarantee full payment on at least 90% of all claims filed for covered services.

The range and 90th Percentile will be continually revised and updated based on charges reflected on claims submitted by physicians. As the data from claims indicate such need, consideration will be given to the re-alignment of the medical-economic areas.

For claims administration the 90th Percentile technique will be the basic guideline and all claims for covered services within this range are to be processed routinely. When claims are received with charges that exceed this guideline, Blue Shield and

*Chairman, KMA Claims Review Committee

third parties should make every effort to resolve these claims without sending them to a review committee.

A letter will be sent to the physician submitting the claim asking if there were any extenuating circumstances involved in the services he rendered and if so, request the physician to furnish the additional information. When the additional information is received, the case is to be given special consideration and may at this point be paid.

If, however, the claim is still not resolved a representative of Blue Shield or the third party involved will make a personal contact with the physician. The representative will explain and discuss with the physician the mechanism of the Usual and Customary Program and seek any additional information that would be helpful in determining a proper allowance. If the case still cannot be resolved the representative will explain the referral of the case to the appropriate peer review committee (if needed).

The review mechanism will be responsible for reviewing cases from Blue Shield, third parties and government when benefits are provided under the Usual and Customary concept. When a case is referred to a committee, Blue Shield or the appropriate third party will prepare and make available for the committee's use a photocopy of the claim and all correspondence, the physician's specialty or field of practice, the medical-economic area, the incurred date of the service, the procedure number, a description of the service, the most prevalent fee for the service within the medical-economic area, the physician's submitted fee and a resume of all action taken on the claim.

Our Committee felt that this should be sufficient information for a claims review committee to make an adequate review and recommend an allowance to be considered as payment in full.

For the KMA Claims Review Committee, all cases will first be referred to the representative of the specialty or field of practice for his review and recommendation to the rotating Executive Committee which will be responsible for reviewing cases at the state level. This Executive Committee will meet on call by the chairman. Any case that cannot be resolved by the Executive Committee will be referred to the committee of the whole for consideration.

The Committee felt that while reviewing cases every effort should be made to maintain the confidentiality of the 90th Percentile. In no instance will the physician's name be identified on any case reviewed.

Our Committee reviewed the Blue Shield Usual and Customary Program and approved it as being within the overall guidelines. We requested and Blue Shield agreed that Blue Shield representatives be available to work with and assist the county societies in the development of local review committees.

In addition to this article, as directed by the Committee, these guidelines are being disseminated to the county society secretaries and the Health Insurance Council.

Mark Your Calendar

KMA Interim Meeting

March 26-27

Continental Inn

Lexington

(See program on page 133)

Medical Economics says:

GENERAL LEASING'S PLAN IS

"The Winning Way"

TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ Leasing better than buying
- ★ No capital investment
- ★ Dependable car at all times
- ★ Certain tax advantages
- ★ Call us for particulars

LEASE
Medical or Surgical
EQUIPMENT

- ★ A plan for young doctors
- ★ Medical and Surgical equipment
- ★ Complete office furnishings
- ★ Enlarging facilities
- ★ Call us for full details

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

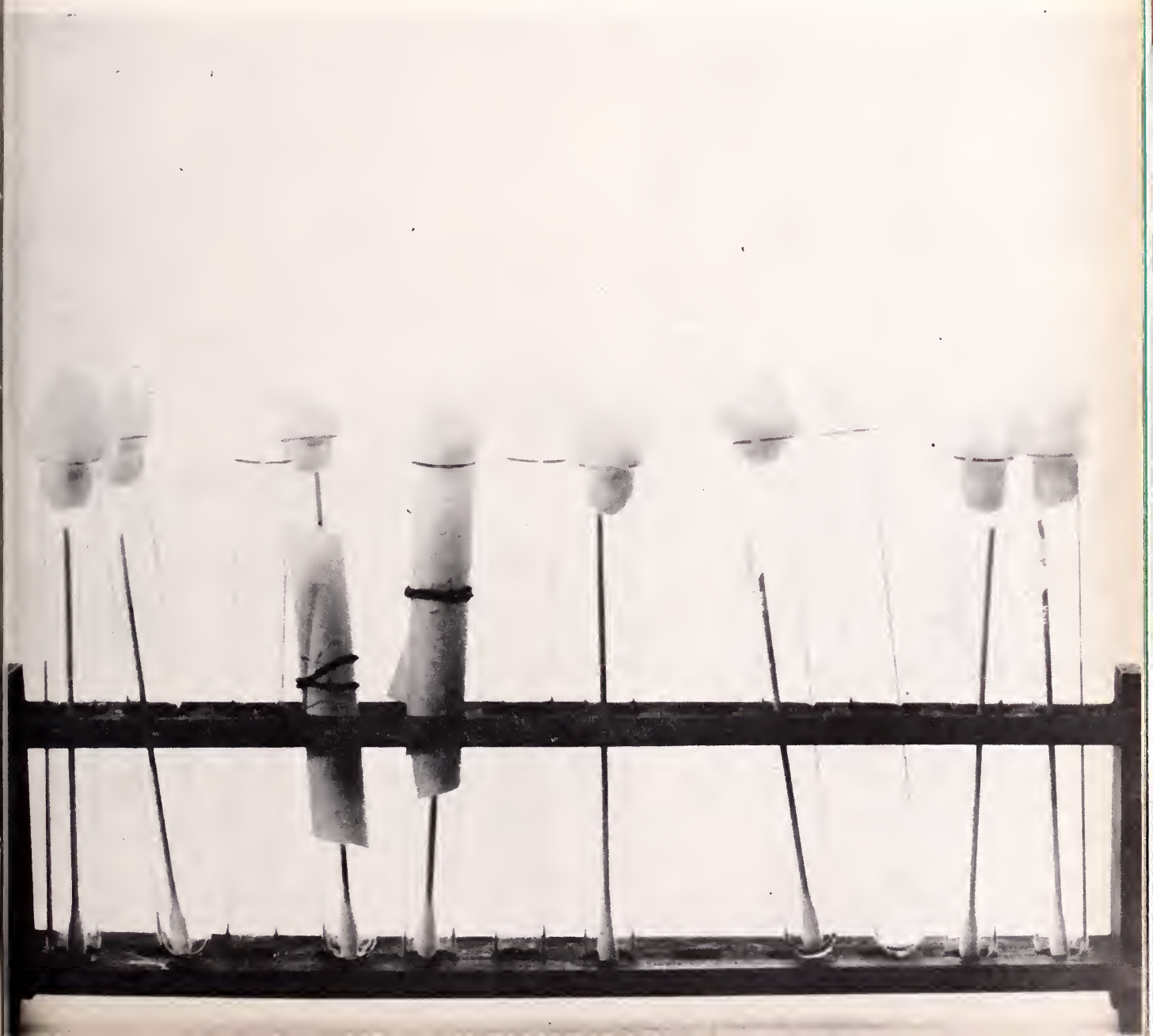
Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE
Lederle

The price differential is inconsequential.





EDITORIALS



Kentucky Medicine

LAST MONTH'S Journal cover reflected the views of your editors in regard to the content of this publication. It is our feeling that the scientific pages of the *Journal* should afford an opportunity for all physicians of the Commonwealth to contribute to one another.

Presently all physicians' desks are deluged by journals. These publications provide a wide range of articles, from broad reviews of medical progress to esoteric reports of single cases. There is no dearth of papers submitted to these journals. Rather, it is the exception, not the rule, if a single author's paper is accepted for publication by a journal with national circulation because of the competition to "publish or perish."

It is our belief that there are many things about Kentucky medicine which should and could be reported on the scientific pages of this *Journal.* Therefore, we have chosen to emphasize the word "Kentucky" on the cover.

Since I became scientific editor 18 months ago, I have reviewed each article submitted for publication. The majority of these papers have originated in Louisville, Lexington and Covington, or have been submitted at our request by speakers at our Annual Meeting. For this we are grateful. However, we believe we have not plumbed the depth of scientific material available from our practicing physicians and their offices and community hospitals. Furthermore, we think that this reservoir of untapped authors would be surprised at how easy it is to get into print!

Several examples of types of articles come to my mind: (1) Reviews of experience with a common (or uncommon) disease in a community hospital; (2) Reviews of experience with a single disease in office practice; (3) Case reports, single or multiple, which illustrate a new point or reiterate an old one; (4) Reports on new procedures in office or hospital practices; (5) Reports of drug reactions not previously reported; and (6) "Chauvinistic" articles about what "we" have found that others haven't.

The prevalence of streptococcal disease (and rheumatic heart disease), viral hepatitis, and emphysema, as well as the occurrence of sporadic cases of brucellosis, tularemia, and Rocky Mountain spotted fever, provide fertile fields for papers. The occasional case of iron deficiency anemia due to starch ingestion, malabsorption due to strongyloides, or lycopenemia due to too much tomato juice on a weight-watcher's diet can educate us all.

So we are issuing a call to all our members to respond with more papers with the "flavor" of Kentucky medicine. Now we don't want them too "folksy" as witness a tale of Joseph Garland, former editor of the *New England Journal of Medicine:*[1]

> I remember well one such addict to horsechestnutmanship (horsechestnuts carried in the pocket to ward off rheumatism) who averred that he had carried a buckeye, or a succession of them, continuously for 6 years, during which time he had been absolutely free from rheumatism.
>
> "And had you been greatly troubled before that," I asked.
>
> "That's the most remarkable thing of all," he replied. "It's retroactive."

We do feel that you can work up a paper satisfactory from the editorial standpoint to publish. We will look for your response, from "the Big Sandy to the Purchase" as well as Louisville, Lexington and Covington.

[1]Garland, J.: The joys and rewards of an editor. *Bull. Amer. Med. Writers' Assn.* 12:47, 1962.

CHARLES C. SMITH, JR., M.D.
SCIENTIFIC EDITOR

Nurse!

AN INTERESTING article by W. B. Rogers Beasley, M.D., appearing elsewhere in this issue of *The Journal,* surveys the current duties of office nurse-assistants in eastern Kentucky. The author mentions in his introductory paragraph the many expanding fields of para-medical training, and proceeds to suggest that the "upgraded nurse," who has added special skills to her general nursing knowledge, may be the logical assistant to whom the physician can turn for effective help, as he strives to care for an increasing patient load with increasingly sophisticated methods.

While the survey results indicate physician approval, at least from those on the scene, of an expanded role for the nurse-assistant (i.e. more history-taking, record keeping, injections, dressings, even certain aspects of physical exams), it is apparent that several factors will influence the role of the nurse-assistant in the near future. Chief among these factors is the changing role of the nurse herself, as she and her educational process struggle for a new self-identity.

At a recent meeting here in Kentucky between physicians and nursing educators, it was made clear that the entire process of nursing education is in the process of upheaval. The number of girls entering the profession is not expanding to match the need, and programs vary now from a one-year course producing L.P.N.'s, through two-year hospital based diploma schools, three-year hospital based diploma schools, two-year associate-degree schools, (centering around Community Colleges), and baccalaureate degree schools. We were told we need to add, further, facilities for graduate degree programs in this state, and I'm sure that we do. If this is confusing to physicians, how completely incomprehensible it must seem to the prospective nursing student, who sincerely wants to help sick people by just being **a nurse!**

The trend, then, in nursing education, and in nursing itself, is toward higher education and managerial status. This trend, plus the unsatisfied need for nurses in our expanding hospitals, would seem to indicate that we will have difficulty attracting nurses for office-based work, and if we do successfully compete for them, we'll do so at the expense of our in-hospital population.

Recognizing this personnel problem, medical educators across the country are introducing training programs designed to tap previously untouched student sources—i.e. schools of medical technology. These schools (as at University of Kentucky and Pennsylvania) produce specialists in various fields, such as laboratory technicians, inhalation therapists, physical therapists, X-ray technicians, etc. and, by broadening the base of medical care, do indeed relieve the busy physician of some of his tasks.

The American Association of Medical Assistants is at present attempting to set standards of information and performance for office assistants, and has carried out at least one prototype certifying examination. Most of these girls are not nurses (although there is no rule that they can't be); it would seem that we as physicians have everything to gain by supporting this group in their quest.

We do certainly need more attention paid by the profession to the field of medical assistants; all indications are that the public and the profession are ready for an expansion in that direction. Such assistants however, 1) must be carefully trained, 2) should be subject to a nationally-based certification examination, and 3) have to be, to preserve our form of medical care, under a physician's guidance and responsibility.

We thank Doctor Beasley for his careful and provocative study.

WALTER I. HUME, JR., M.D.

Coquette

IT'S a gas to discover that you have prepared early for life and then to find that your composition is only an introduction.

Senior Day for our two medical schools is Monday, March 17, at the Executive Inn, Louisville. All are invited. It's an invitation for each of us to help continue all that has gone before by coming into a closer association with our student fellows and our next generation of doctors. It's a challenge also because things are changing, opportunities are greater and the panorama of life is speeding on and presumably up.

Think upon the following proposition and if you believe attend the Senior Day proposition.

Most physicians at the completion of training have a myriad of feelings ranging from awe to elation. With experience, personal patient exposure and following the well advised admonition of "not with force but with skill," one develops an inner strength of self confidence. While good, it can also be an unsuspecting snare. It can support and sustain a personal position of "everything is solvable" or the sometimes heard "Here's the way to do it."

The world is obviously smaller communications and transportation wise. At the same time it is vastly more large and complex with personal relationships. Things are not like they were and never can be again.

We in the practice of medicine are now challenged to keep abreast of the interrelationships of the coming generations of physicians. These also will not be the same. Their concepts are different. Their education is different. They are restless and instead of "watchful expectancy" are more prone to "trail blaze." Traditions are challenged and it doesn't seem to bring much response to be venerable anymore.

Such being the case we currently, perhaps very transiently, being in the main stream can be a stimulating posture. We can by some empathy with our coming rebirth in the ranks by new graduates be informed and perhaps enthused in some areas by new life. At the same time we can give the new species their needed conditioning of background. In other words, we all can have it both ways. There is no valid or reasonable person who should think that we of today and those of tomorrow are not "mutually compatible."

Thus we are being flirted with and courted by that imp of challenge which says participate. However good we are as doctors or as a profession cannot be revealed if not exposed. Close communication and complex personal relationships insist, if they are to be cohesive and mutually satisfying, that all interested parties get together and be a part of the others existence.

To do so means a personal identification for ourselves and a problem solving organization for all. To do less will mean a lonely seldom traveled road of isolation within ones own confines and with no approach to and no rapport from without.

So we are being winked at by the coquette of a broader life. Will you accept the proposal or deny fate?

HOYT D. GARDNER, M.D.



Joseph Gant Gaither, M.D.
1884-1968

JOSEPH Gant Gaither, M. D., president of the Kentucky Medical Association during the 1955-56 Associational year, died December 3, 1968, at Jennie Stuart Hospital, Hopkinsville, Kentucky after a long illness. Doctor Gaither's life was dedicated to the services of his God, his Country and his fellow man.

A native of Hopkinsville, Doctor Gaither attended the city schools, South Kentucky College and received his bachelor's degree at the University of the South, Sewanee, Tennessee. After serving one year as a reporter for the *Memphis Commercial Appeal,* he returned to the University of the South Medical School and graduated in 1907 as valedictorian and president of his class.

Doctor Gaither was in general practice in Mississippi for three years before deciding to limit his practice to general surgery. Following further training at Oxford, Mississippi and Vicksburg, Mississippi, he returned to Hopkinsville in 1912 to establish his 45-year practice in general surgery. At this time he was a true pioneer, as he was the only surgeon between Evansville, Indiana and Nashville, Tennessee and between Bowling Green and Murray, Kentucky.

Doctor Gaither volunteered as a Captain in the Army during World War I. He served as an instructor in the School of Military Surgery at Camp Greenlief, Georgia along with other military duties. He remained in the Medical Reserve Corps for many years and attained the rank of Lieutenant Colonel. He was quoted as saying that taking the oath of office as Captain was one of the most important and thrilling events of his life.

An active member of Grace Episcopal Church, Doctor Gaither served as senior warden. At times, when the local church had no rector, he served as a lay reader. For several years, he conducted regular services at a local mission.

Doctor Gaither was a Fellow of the American College of Surgeons, and belonged to many medical societies. He was recognized for his outstanding contributions to organized medicine, and to civic affairs on local, state and national levels. He was admired and respected by his colleagues in the profession, as well as by his many patients and fellow citizens. He was truly a physician, a gentleman and a scholar.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-253-2761

The CONTINENTAL INN

Extends a Warm Welcome to the

KENTUCKY MEDICAL ASSOCIATION

during its **INTERIM MEETING**

March 26-27

May your visit with us be an enjoyable one



- **Distinctive Dining**
- **Versatile Convention Facilities**
- **Luxurious Accommodations**

801 New Circle Rd. N.E.
Lexington
Phone (606) 299-5281

ORGANIZATION SECTION

KMA Interim Meeting To Feature Discussions of Health Manpower, Comprehensive Health Planning March 26-27 in Lexington

Lively and stimulating discussions of Health Manpower and Comprehensive Health Planning will be presented by experts in these fields during the 1969 KMA Interim Meeting March 26-27 at the Continental Inn, Lexington.



Doctor Wood

The Honorable Louie B. Nunn, governor of Kentucky, will deliver the keynote address at the opening dinner session March 26. Governor Nunn, director of the Health Planning Commission, will present an over-all picture of recent developments in Comprehensive Health Planning within the state.

The theme will be continued in a panel discussion during the March 27 morning session, moderated by George F. Brockman, M.D., Greenville, KMA immediate past president. Participants in this discussion and their topics are Frank Groschelle, Frankfort, administrator of the Kentucky Program Development Office, "Area Development in Kentucky"; Strawn Taylor, Frankfort, director of Comprehensive Health Planning, "Area Health Planning"; Senator Clyde Middleton, Covington, chairman of the State Health Planning Council, "The Consumer's Role in Local Health Planning"; and Frederick A. Stine, M.D., Ft. Thomas, member of the State Health Planning Council, "The Physician's Role in Local Health Planning."

Preceding the panel discussion, talks will be presented on Health Manpower by Donald E. Wood, M.D., Indianapolis, Ind., and Norman E. Farber, New York, N.Y. Doctor Wood, whose topic will be "Health Manpower—Mostly!", is a member of the AMA Health Manpower Council and chairman of the AMA Council on Legislative Activities. He is a former president of the Indiana State Medical Association and chairman of the department on medical economics at Indiana University School of Medicine.

Mr. Farber, recently appointed Director of the Health Careers Program of the National Health Council, will discuss aspects of this program. In his new position, Mr. Farber serves as liaison with national health agencies and professional societies. He previously served as coordinator for the Office of Manpower, Automation and Training Project.

The meeting will close with a luncheon session featuring a talk entitled "Blue Shield's Partnership with Medicine." The speaker will be George Dunlop, M.D., Boston, Mass., president of Massachusetts Medical Service and a member of the Board of the National Association of Blue Shield Plans.

In addition to the outstanding program outlined above, the Interim Meeting will include an Orientation Course for new KMA members, and meetings of the KMA Board of Trustees and the Woman's Auxiliary.

All physicians are urged by KMA President Henry B. Asman, M.D., Louisville, to secure reservations now at the Continental Inn for this exciting two-day session. (The complete program, released by Doctor Asman at press time, appears on the opposite page.)

KMA Awards Committee To Accept Nominations at Interim Mtg.

The KMA Awards Committee will accept nominations for KMA's three top awards during the 1969 Interim Meeting, according to Richard F. Grise, M.D., Bowling Green, committee chairman.

The committee will be seated at a reserved table during the March 27 luncheon and at that time will accept nominations for the Distinguished Service Medal Award, Outstanding General Practitioner Award and the R. Haynes Barr Award. These awards will be given during the KMA Annual Meeting in September.

In addition to Doctor Grise, members of the Awards Committee include William A. Blodgett, M.D., Louisville; Frank L. Duncan, M.D., Monticello; C. Wayne Franz, M.D., Ashland; and Joseph Keith, Jr., M.D., Lexington.

David J. Brecount, M.D., an internist, is a full-time faculty member at the University of Kentucky Medical Center Health Service. Doctor Brecount graduated from the University of Cincinnati Medical School in 1960. He completed his internship at Cleveland Metropolitan General Hospital and his residency training in the Public Health Service Hospital, San Francisco, Calif.



Governor Nunn

Program

"The Challenge We Face in 1969"

KMA 1969 Interim Meeting

March 26 and 27

Continental Inn
Lexington



Doctor Dunlop

WEDNESDAY EVENING SESSION

Henry B. Asman, M.D., Louisville, president
Kentucky Medical Association, presiding

3:00 p.m. Registration

5:30 p.m. Social Hour

6:30 p.m. Dinner

Invocation—Father Edward Murray, Pastor, St. Paul Catholic Church, Lexington

7:30 p.m. Call to Order —Doctor Asman

Keynote Address—The Honorable Louie B. Nunn, Governor, Commonwealth of Kentucky

THURSDAY MORNING SESSION

Doctor Asman presiding

9:15 a.m. Call to Order and Announcements

9:30 a.m. "Health Manpower—Mostly!" —Donald E. Wood, M.D., Indianapolis, Ind., Member, AMA Health Manpower Council

9.50 a.m. "Health Careers Program of the National Health Council" —Norman E. Farber, New York, N.Y., Director, Health Careers Program, National Health Council

10:15 a.m. Coffee Break

10:30 a.m. Panel Discussion—"Comprehensive Health Planning"

"Area Development in Kentucky"—Frank Groschelle, Frankfort, Administrator, Kentucky Program Development Office

"Area Health Planning" —Strawn Taylor, Frankfort, Director, Comprehensive Health Planning

"The Consumer's Role in Local Health Planning" —Senator Clyde Middleton, Covington, Chairman, State Health Planning Council

"The Physician's Role in Local Health Planning"—Frederick A. Stine, M.D., Ft. Thomas, Member, State Health Planning Council

MODERATOR: George F. Brockman, M.D., Greenville, KMA Immediate Past President

11:30 a.m. Question and Answer Session

LUNCHEON SESSION

12:30 p.m.

Walter L. Cawood, M.D., Ashland
KMA President-elect, presiding

Invocation—Father Garland O'Neil, Chaplain, St. Joseph Hospital, Lexington

"Blue Shield's Partnership with Medicine"—George Dunlop, M.D., Boston, Mass., President, Massachusetts Medical Service

Adjournment



Doctor Stine



Mr. Taylor



Senator Middleton



Mr. Groschelle

New Member Orientation Course To Be Offered March 26

The Eighth KMA Orientation Course for new members of the Association will be offered March 26, just prior to the opening of the 1969 Interim Meeting at the Continental Inn, Lexington.

New members are required to attend an orientation program within two years of joining the Association, in accordance with the KMA Bylaws.

Letters of invitation for this course, which is held twice each year in connection with the Interim and Annual Meetings, have been sent to new members. All physicians, whether new members or not, are invited to attend the session.

Senior Day Program To Feature Completely Redesigned Format

The 1969 KMA Senior Day format has been completely redesigned this year, according to Hoyt D. Gardner, M.D., chairman of the KMA Senior Day Committee. The program, scheduled March 17 at Exeutive Inn, Louisville, will feature a joint session for the senior medical students of both the University of Louisville and the University of Kentucky.



Reverend Slider

The afternoon session will include four presentations followed by four separate discussion groups. Speakers and their subjects for this portion of the program include "Features of Organized Medicine", Robert C. Long, M.D., Louisville; "Medical Ethics and Courtesies", N. Lewis Bosworth, M.D., Lexington; "Medical Records and Malpractice", Fred M. Goldberg, Loiusville; and "Medical Legislation and Politics", Frank J. Groschelle, Frankfort. The overall theme for the program is "The Delivery of Medical Care".

The carefully planned presentations are designed to assist the medical students in bridging the gap between academic and the actual practice of medicine. This marks the sixth annual program for the University of Kentucky seniors and the fifteenth for those of the University of Louisville. In previous years separate Senior Day programs were held in Louisville and Lexington.

The Reverend Doctor William W. Slider, Christ Methodist Church, Louisville, will be the guest speaker at the evening session, following a social hour and dinner sponsored by the Jefferson and Fayette County Medical Societies.

Doctor Slider has gained national recognition as an after dinner speaker and has accepted speaking engagements in 20 states this year.

Doctor Gardner emphasized appreciation of his committee members and the official family of KMA for the cooperation of the two medical schools and the support of the Jefferson and Fayette County Medical Societies in making these programs possible.

AMA Committee Appointments Include Eight Ky. Doctors

The Board of Trustees of the American Medical Association appointed or reappointed eight Kentucky physicians to membership on its councils and committees at a December, 1968 meeting. The terms of the appointments are for one year with maximum tenure of 10 consecutive terms.

William T. Rumage, Jr., M.D., Louisville, was appointed to the Council on National Security and reappointed chairman of the Committee on Disaster Medical Care.

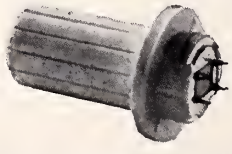
Other reappointments include George F. Brockman, M.D., Greenville, Committee on Planning and Development; William K. Keller, M.D., Louisville, Committee on Medical Aspects of Automotive Safety; Nicholas J. Pisacano, M.D., Lexington, Committee on Rehabilitation; and Donn L. Smith, M.D., Louisville, Council on Drugs.

Reappointed to Interspecialty Committees were Robert W. Lykins, M.D., Louisville, American Society of Anesthesiologists; and Carroll L. Witten, M.D., Louisville, American Academy of General Practice.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

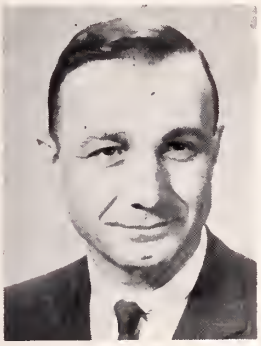
Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

Lexington Clinic Conference Scheduled April 3

The Fourteenth Annual Clinical Conference of the Lexington Clinic will be highlighted by the Carl Fortune Lecture at 11:30 a.m. April 3, according to James W. Bard, M.D., Lexington, program chairman.



Doctor Pellegrino

Edmund D. Pellegrino, formerly of Lexington, will deliver the lecture entitled "Uremic Bone Disease." A 1944 graduate of the New York University Medical School, Doctor Pellegrino served as chairman of the department of medicine at the University of Kentucky Medical Center from 1959 to 1966. He is currently vice president for health sciences, director of the Health Sciences Center and professor of medicine at the State University of New York, Stony Brook.

Beginning at 9 a.m., the Conference will feature discussions of a variety of medical topics by Clinic staff members. The luncheon address, "50 Years of Kentucky Medicine," will be presented by Francis M. Massie, M.D., Lexington. Leslie W. Blakey, M.D. and Wilford L. Cooper, M.D., Lexington, will moderate the morning and afternoon sessions respectively.

Heart Association Symposium Planned March 26-27

The Fifteenth Annual Symposium on Cardiovascular Diseases of the Heart Association of Louisville and Jefferson County has been scheduled March 26 and 27 at the Brown Hotel, Louisville.

A number of nationally prominent heart specialists will participate in the two-day session which will be acceptable for 11 prescribed hours by the American Academy of General Practice.

Included among the speakers are Walter M. Kirkendall, M.D., director of the Cardiovascular Research Laboratories, University of Iowa Hospitals; Louis N. Katz, M.D., director emeritus of the Cardiovascular Institute, Michael Reese Medical Center, Chicago; and Henry D. McIntosh, M.D., chief of the cardiology division of the Duke University School of Medicine, Durham, N.C.

SMA Section Elects Dr. Parker

The Section on Neurology and Psychiatry of the Southern Medical Association announced recently the election of Joseph B. Parker, Jr., M.D., Lexington, as its chairman. Doctor Parker and other newly elected officers will arrange the program for the Section's 63rd Annual Meeting during the SMA convention November 10-13 in Atlanta, Ga.

HAVE YOU REGISTERED?

The deadline for registration to vote in the May 27 primary election is March 29. Have you checked your registration status to be sure that you are eligible to vote in this important state and local election?

The editors of *The Journal* urge you to remind your family and staff to register also by March 29 and to vote on May 27.

U of L Smith Lecture Set

The annual L. E. Smith lecture at the University of Louisville has been scheduled for March 20. Selected to give the address is Alfred P. Fishman, M.D., professor of medicine at the University of Chicago and director of the Michael Reese Hospital and Medical Center's Cardiovascular Institute.

Doctor Fishman is a 1943 graduate of the University of Louisville School of Medicine. The Smith lectures are presented annually at the University of Louisville and the University of Kentucky in memory of the late Doctor Smith, a pioneer in Kentucky tuberculosis work.

7 KENTUCKY
STATE RESORT PARKS



OPEN YEAR-ROUND

Planned recreation programs and special evening entertainment

- CUMBERLAND FALLS at Corbin
- KENTUCKY DAM VILLAGE at Gilbertsville
- GENERAL BUTLER at Carrollton
- LAKE CUMBERLAND at Jamestown
- JENNY WILEY at Prestonsburg
- NATURAL BRIDGE at Slade
- CARTER CAVES at Olive Hill

SPECIAL PACKAGE RATES

5 days and 4 nights in a luxurious lodge room with two double beds, including entertainment and all meals from Sunday evening dinner through Thursday lunch. Every week, October 13-March 31.

$44.00 Per Person (double occupancy) (plus tax)

Call Central Reservations, Frankfort • 502-223-2326 or see your local travel agent.
For a brochure, write TRAVEL, PDB-FW, Frankfort, Ky. 40601

Digest of Board of Trustees Minutes December 11-12, 1968

The second meeting of the KMA Board of Trustees during this Associational year was a special called meeting on Wednesday evening, December 11. The two subjects considered by the Board were Health Careers and Comprehensive Health Planning.

Mr. Tom Connelly, program director for the Health Careers in Kentucky Foundation, made a detailed explanation of this new project designed for the allied health professions to interest young Kentuckians in a health career. A thorough discussion was then held on Comprehensive Health Planning with proposals and comments being presented by Mr. Strawn Taylor, director of CHP in Kentucky, and Hoyt Gardner, M.D., Louisville, a member of the state Comprehensive Health Planning Council.

The Board of Trustees then met in regular session December 12 and accepted for information the President's Report, Headquarters Office Report and reports from the senior delegate to the AMA and AMA Board of Trustees member, Robert Long, M.D., Louisville. Action was taken authorizing KMA's continuing financial participation in "Health Careers in Kentucky", approving funds for the Woman's Auxiliary membership on the state Advisory Council of Health Careers in Kentucky and naming an alternate KMA member to this same advisory council.

Nominees were confirmed for vacancies on the State Board of Health, Clinical Laboratories Advisory Board and Advisory Council for Health Facilities. Procedures for the election of the Chairman of the Board and members of the Executive Committee were approved and annual registration of physicians and Annual Meeting exhibits were discussed.

The guidelines for implementing usual and customary fee programs of all third parties through the KMA Claims Review Committee and county review committees were approved with a request that the guidelines be published in the KMA Journal and disseminated to county society secretaries. The date of KMA's Congressional Dinner in Washington, D. C., was set for May 13 and a status report of the March 26-27 Interim Meeting in Lexington was presented.

Thorough presentations were made concerning administration of the Title XIX program, activities of the Governor's Advisory Council for Medical Assistance, and implementation of the Advertising or Soliciting by Practitioners of the Healing Arts Act as specifically related to a case in Lexington involving a chiropractor. Endorsement was given to an Emergency Communications project of the Kentucky Hospital Association, the distribution of a letter to physicians relative to an eastern Kentucky ambulance attendant training program, and the naming of a KMA member to the KEMPAC Board of Directors.

A referral to the Bylaws Committee would authorize non-voting seats in the House of Delegates to a representative of the Student AMA from each of the medical schools, and a KMA sustaining membership in the Student AMA was approved. Recommendations were made concerning the TB Hospitals in Kentucky with responsibility for a more thorough study referred to KMA's Comprehensive Health Planning Committee. It was agreed that KMA would testify before state hearings on this subject.

The Chairman of the Board appointed a new Plans and Development Committee, an action approved by the Board in September. Final subjects discussed were Selective Service matters, activities of the Cults Committee, physicians on hospital boards, and the desirability of having a school health coordinator in each school district.

Doctors, Wives Urged To Help In Project MED-AID:MARCO

Kentucky physicians and their wives are urged to participate in Project MED-AID:MARCO by Mrs. J. Jack Martin, Tompkinsville, chairman of the International Health Activities for the Woman's Auxiliary to the AMA.

Mrs. Martin defines MED-AID:MARCO as a project designed "to distribute good workable communication equipment to physicians and medically oriented mission establishments in those areas of the world where there is no acceptable form of communication, particularly on an emergency basis, and when and where such equipment is legally permissible."

Organizations involved in the project include MED-AID, an amateur radio station in daily contact with remote areas receiving and transmitting emergency medical information; MARCO, a charitable, non-profit organization founded in 1966 and composed of doctors and others who are amateur radio operators; and the Woman's Auxiliary to the AMA, working to determine sources of acceptable amateur radio gear and arranging shipment of the equipment to areas where needed.

Complete information concerning this project may be obtained from Mrs. Martin, 605 Fifth Street, Tompkinsville, Ky. 42167.

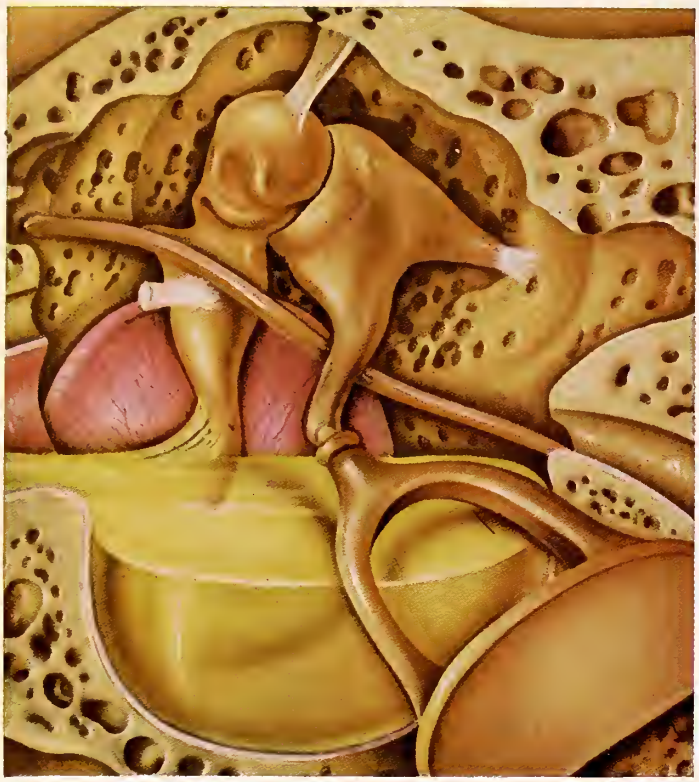
TWO INTERNISTS—Board Eligible or Certified, wanted by multi-specialty group in Central Texas Associated with 100-bed hospital; $20-$24,000 annual salary; early partnership; no investment. Write G. H. Wahle, Jr., M. D. King's Daughters Clinic, Temple, Texas, or call collect 817 778-5501.

See next page for prescribing information



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strain may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged actio permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocoliti pruritus ani. Skin—maculopapular and erythematous rashes; a ra case of exfoliative dermatitis has been reported. Photosensitivit onycholysis and discoloration of the nails (rare). Kidney—rise in BU apparently dose-related. Transient increase in urinary output, som times accompanied by thirst (rare). Hypersensitivity reactions—urt caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (ye low-brown) in children of mothers given this drug during the latter ha of pregnancy, and in children given the drug during the neonatal pe od, infancy and early childhood. Enamel hypoplasia has been seen a few children. If adverse reaction or idiosyncrasy occurs, discontin medication and institute appropriate therapy. Demethylchlortetr cycline may form a stable calcium complex in any bone-forming tiss with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shoul be given 1 hour before or 2 hours after meals, since absorption impaired by the concomitant administration of high calcium conte drugs, foods and some dairy products. Treatment of streptococc infections should continue for 10 days, even though symptoms ha subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 3 mg, 150 mg and 75 mg of demethylchlortetr cycline HCl. 39

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410RE9

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



introducing an anticostive* antacid

*Avoids constipation.

an antacid formulated especially for the constipation-prone patient

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-92-4C

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1969 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 23, 24, 25**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

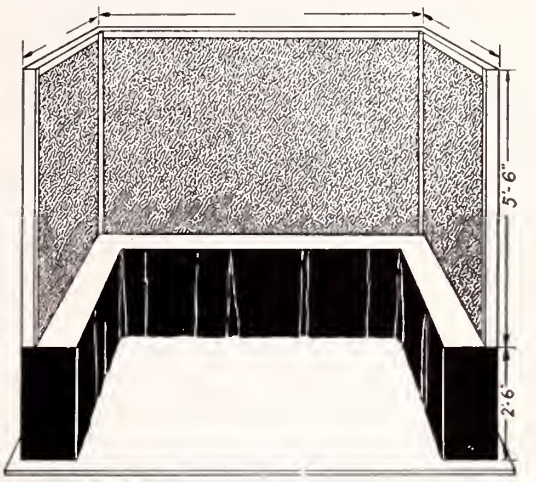
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1969

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)

 Institution (if desired):

 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)

 Charts and Posters.... Photographs.... Drawings.... X-rays

 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

 Amount of total wall space needed?

 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided to you in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



The first 400 mg. Trocinate tablet usually relieves discomfort so promptly that Diarrhea ceases to be a bother

Trocinate has no known therapeutic value other than relaxing smooth muscle by direct action when coming in contact with the spastic muscle cell. Trocinate has none of the troublesome side-effects of anticholinergic drugs. Trocinate relieves the discomfort of diarrhea by decreasing both peristalsis and muscle tone. Trocinate is metabolized by the body and eliminated in the urine as harmless degradation products. Normal intestinal function is resumed.

The action of Trocinate is prompt, making the spacing of dosage easy. Often one or two 400 mg. tablets are sufficient to control diarrhea. The recommended dosage in spasm of the G. I. and G. U. tract is 400 mg. q. 4 h. A prescription of twelve (12) 400 mg. tablets will, in most cases, allow the patient to have a few to keep in reserve.

Literature and samples available

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



In Memoriam

R. DOUGLAS BARTON, M.D.
Louisville
1906-1968

R. Douglas Barton, M.D., 62, chief of admission services at Veterans Hospital, Louisville, died December 24 at his home. Doctor Barton graduated from the University of Louisville School of Medicine in 1932 and was in private practice as a surgeon in Frankfort, Campbellsville and Lebanon before coming to Louisville seven years ago.

OSCAR E. BLOCH, JR., M.D.
Louisville
1907-1968

Oscar E. Bloch, Jr., M.D., 61, a Louisville internist, died December 23 at Methodist-Evangelical Hospital. Doctor Bloch graduated from the University of Pennsylvania School of Medicine in 1933. He was an associate professor of medicine at the University of Louisville School of Medicine and a member of the Louisville Society of Medicine and the Louisville Society of Internists.

WALTER F. McCROCKLIN, M.D.
Louisville
1890-1968

Walter F. McCrocklin, M.D., 78, a retired Louisville surgeon, died December 27 at Kentucky Baptist Hospital. A 1917 graduate of the University of Louisville School of Medicine, Doctor McCrocklin practiced in Louisville until his retirement 10 years ago, except for service in the military and during his surgical training at the Cleveland Clinic. He was a diplomate of the American Board of Abdominal Surgery and a former president of the Louisville Urological Society.

EMERGENCY ROOM PHYSICIAN

Accredited 280 bed progressive general hospital. Guaranteed annual income. Immediately available. Contact Administrator, Cabell Huntington Hospital, 1340 16th St., Huntington, West Virginia.

DON'T BE A

DOCTOR DROP-OUT!

ATTEND

THE CHICAGO MEDICAL SOCIETY

MIDWEST CLINICAL

CONFERENCE

MARCH 2-5, 1969 PALMER HOUSE, CHICAGO

A "MUST" MEETING FOR

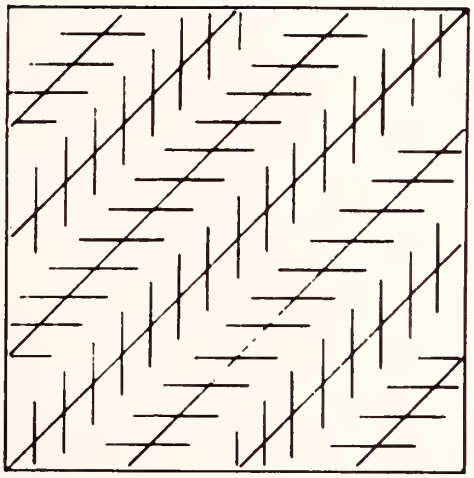
ALL PHYSICIANS

MARK YOUR CALENDAR NOW!

Write 310 S. Michigan Avenue, Chicago 60604 for complete details.

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

Pertofrane®, desipramine hydrochloride
Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for

You decide who needs how much

PRESCRIPT



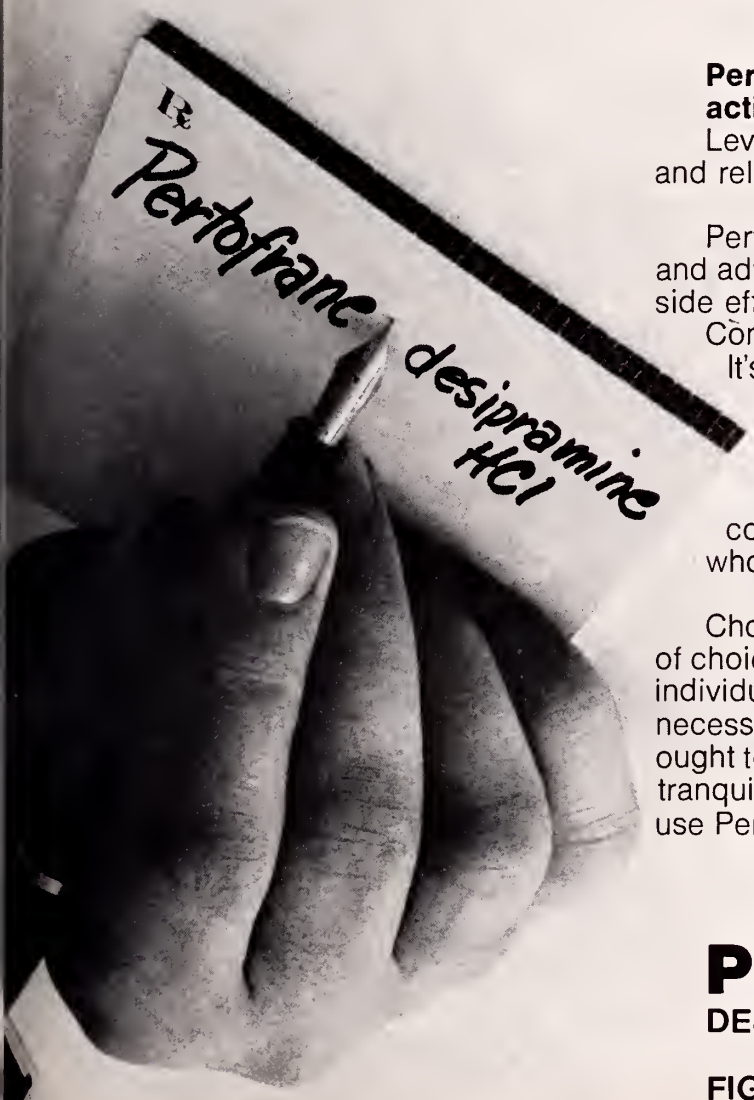
treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000.
(B) 46-530-E

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

antidepressant and how much tranquilizer—

ON POWER



Pertofrane can give rapid antidepressant action often within 3 to 5 days.
Levels of psychomotor activity, patient outlook and related somatic complaints may improve.

Pertofrane is well tolerated by most patients and adverse reactions are usually mild. A few serious side effects have been reported infrequently. Consult full prescribing information before using. It's summarized above.

Anxious Depressives...
May require adjunctive use of tranquilizers; but they don't always fit ready-made drug combinations. Isn't it better for *you* to decide who needs how much of which drugs?

Choose Pertofrane and pick your tranquilizer of choice. With this "combination", control the individual drug dosage adjustments that may be necessary for proper therapy. Isn't that the way it ought to be? Please remember, phenothiazine tranquilizers may aggravate depression, and never use Pertofrane with an MAO inhibitor.

PERTOFRANE®
DESIPRAMINE HYDROCHLORIDE **Geigy**

FIGHTS DEPRESSION

F-6561

Thoracic Society Elects Officers

Paul Pichardo, M.D., Glasgow, was recently named president-elect of the Kentucky Thoracic Society, according to a release from the Kentucky TB and Respiratory Disease Association. Doctor Pichardo is medical director of the Glasgow State TB hospital.

Richard B. McElvein, M.D., Lexington, was elected secretary-treasurer of the Society. Joseph H. Humpert, M.D., South Ft. Mitchell, succeeds E. R. Gernert, M.D., Louisville, as Society president.

Eventration Through Umbilical Hernia

(*Continued from page 112*)

precepts, universally recognized, but too often neglected in the care and management of patients:

1. Umbilical hernias should be surgically repaired in adults, especially in certain high risk groups proven to be susceptible to complications (e.g. females in the child bearing age, elderly patients with large hernias, patients with cirrhosis prior to their developing marked ascites.)

2. Surgical repair of large defects should not be undertaken until the cause of increased intra-abdominal pressure is corrected. In situations where the cause of the pathologic pressure can not be corrected, umbilical herniorrhaphy should be done before the intra-peritoneal pressure progresses to significant levels.

3. The peritoneum tolerates a single challenge well, but repeated or continued contamination must be avoided and aggressive steps taken to prevent it. Skin closure and towel tampon is recommended as a temporary technique in certain clinical situations which preclude an immediate fascial repair.

References

1. Yonemoto, R. H., Davidson, C. S.: Herniorrhaphy in Cirrhosis of the Liver with Ascites, *New Eng. J. Med.*, 255: 733-739 (Oct., 1956).
2. Eisenberg, M. M., Hoye, S. J.: Spontaneous Perforation of Umbilical Hernia, *Arch. Surg.*, 81:514-516 (Sept., 1960).
3. Francis, W. W.: Spontaneous Rupture of Hernia, *Rhode Island Med. J.*, 43: 39-40, (Jan., 1960).
4. Bontecou, R. B.: Rupture of an Umbilical Hernia and Escape of a Large Mass of Intestines; Peritonitis, Opium, Recovery, *Am. M. Month.*, 10:341-344 (1858).
5. McGrath, W. J.: Unusual Case of Umbilical Hernia: Rupture of Skin, *J. Am. Med. Assn.*, 71:1650 (Nov. 16, 1918).
6. MacLean, A. B.: Spontaneous Rupture of an Umbilical Hernia in an Infant, *Brit. J. Surg.*, 38:239 (Dec., 1950).
7. Helmig, V. H.: Uber Sogenannte Spontanrupturen von Hernien, *Schweiz Med. Wschr.*, 88:662-666 (July, 1958).
8. Hardinger, J. D., Noskin, E. A.: Spontaneous Eventration through the Umbilicus, *New Eng. J. Med.*, 261: 141-142 (July, 1959).
9. Rupnik, E. J., Brown, R. P.: Spontaneous Rupture of an Umbilical Hernia, *U.S. Forces Med. J.*, 4: 747-750 (May, 1953).
10. Glanville, H.: Ruptured Umbilical Hernia, *Lancet* 2: 1321 (Dec., 1955).

Health Knowledge

(*Continued from page 114*)

specific action and the extent to which a particular course of action is believed to be beneficial in reducing the threat.[1] Before he will seek medical aid, the potential patient must recognize his individual susceptibility and perceive the seriousness of the problem and its implications. Then he must decide that the benefits of taking action are sufficient to warrant approaching whatever barriers may exist to such action.

As long as the medical community must rely on patients presenting themselves for treatment (and no change in this situation is foreseen), more and better health education of the public is needed. If, in this era of chronic disease detection and early diagnosis, we are to be truly effective in treating the communities we serve, the patient must be recruited as an ally and trained to help himself.

Summary

A random sample of persons living in a rural Kentucky county were interviewed by means of a multiple-choice health knowledge quiz. The correct response rate was approximately 53 percent which compares well with previous studies on urban populations. There was a direct correlation between successful responses and socio-economic status, but no significant differences in response rates when analyzed by age, sex, use of a family physician or distance from the physician.

References

1. Rosenstock, I. M., Why People Use Health Services, *Milbank Memorial Fund Quarterly, 44:* 99-124, July 1966 (Part 2).
2. Feldstein, P. J., Research on the Demand for Health Services, *Milbank Memorial Fund Quarterly, 44:* 128-62, July 1966 (Part 2).
3. Kane, R. L. and Deuschle, K. W., Problems in Patient-Doctor Communications, *Medical Care 5:* 260-71, July-August 1967.
4. Seligmann, A. W., McGrath, N. E., Pratt, L., Level of Medical Information Among Clinic Patients, *Journal of Chronic Diseases, 6:* 497-509, Nov. 1957.
5. Pratt, L., Seligmann, and Reader, G., Physicians' Views on the Level of Medical Information Among Patients, *American Journal of Public Health, 47:* 1277-83, October 1967.
6. Samora, J., Saunders, L. and Larson, R. F., Knowledge About Specific Diseases in Four Selected Samples, *Journal of Health and Human Behavior, 3:* 176-85, Fall 1962.
7. Samora, J., Saunders, L. and Larson, R. F., Medical Vocabulary Knowledge Among Hospital Patients, *Journal of Health and Human Behavior, 2:* 83-92, Spring 1961.

KMA Committee Reports

Health Careers Committee

Joseph Hamburg, M.D., Lexington, Chairman

KMA Headquarters Office **November 7, 1968**

The KMA Health Careers Committee approved specific recommendations for consideration of the KMA Board of Trustees regarding KMA participation in the Health Careers In Kentucky program.

Medical manpower shortages in Kentucky were discussed, and a number of suggestions were made as to how KMA could help alleviate some of the problems.

The Committee adopted the responsibility of serving as liaison between KMA and the Health Careers In Kentucky Foundation, and will serve as a central agency to answer any inquiries concerning Health Careers in Medicine.

Interim Meeting Program Committee

Henry B. Asman, M.D., Louisville, Chairman

Continental Inn, Lexington **November 13, 1968**

The KMA Interim Meeting Program Committee met early during this Associational year and finalized plans for the March 26-27 session to be held at the Continental Inn, Lexington.

Health manpower and comprehensive health planning were the subjects agreed upon for in-depth presentations and speakers were selected to receive invitations to participate on the program. Details of the two-day meeting and promotional plans were completed.

Senior Day Program Committee

Hoyt D. Gardner, M.D., Louisville, Chairman

KMA Headquarters Office **November 14, 1968**

The KMA Senior Day Program Committee met recently to outline plans for the 1969 Senior Day Program to be held in Louisville on March 17. Representatives of both Fayette and Jefferson County Medical Societies were present and discussion centered on ways of making the program more attractive to the senior medical students.

The Committee designed an all new format for this year's program which will bring seniors of both schools together for the first time in a joint session.

Sponsored by KMA, this year's presentation will be the 15th Annual Senior Day for the University of Louisville and the 6th Annual Program for the University of Kentucky.

Claims Review Committee

Roy H. Moore, Jr., M.D., Louisville, Chairman

Blue Cross-Blue Shield Board Room **November 21, 1968**

The Claims Review Committee had its initial meeting of the 1968-69 Associational Year on November 21, 1968. At this time, the chairman explained the reasons for the formation of this new Committee, pointing out that the Advisory Committee to Blue Shield had offered a resolution to the KMA House of Delegates reaffirming the adoption of the usual and customary principle and providing a review mechanism for those claims which cannot be routinely paid.

Technical Advisory Committee on Physician Services (Title XIX)

Carroll H. Robie, Jr., M.D., Louisville, Chairman

State Department of Health, Frankfort **December 5, 1968**

The Technical Advisory Committee on Physician Services met on December 5 to review with the KMAP staff the progress, status, and future programming of usual and customary payment of fees to physicians for out-of-hospital services.

Guests at this meeting were Evan Ray, director of the Division of Medical Care; Mrs. Anne Thompson, acting director of the Kentucky Medical Assistance Division; and William Nash, M.D., director of Medical Affairs of the Kentucky Medical Assistance Division.

Committee on Cults

David B. Stevens, M.D., Lexington, Chairman

KMA Headquarters Office **December 11, 1968**

The Committee on Cults had its initial meeting of the 1968-69 Associational Year on December 11. For the benefit of the new members, David B. Stevens, M.D., chairman, reviewed the past activities of the Cults Committee.

Current activities of cultists and recommendations for possible future plans of the Committee in this regard were discussed.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330-8/6135

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665 President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660 Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123 Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661 Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211 Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282 Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 .. Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 .. Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362 .. 1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525 .. 1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231 1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406 1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751 1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155 1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616 .. 1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357 1969

Buyers Guide

FEBRUARY BUYERS GUIDE FOR JOURNAL OF KMA 1969

Blue Cross-Blue Shield 83
Burroughs Wellcome 140

Cobell Huntington Haspitol 144
Chicago Medicol Society 145
Continental Inn 131

Geigy Pharmoceuticols 84-86, 146-147
General Leasing Corporotion 124

Heart Association of Louisville ond Jefferson County 93
Highlond Hospitol 130
Hynson, Westcott & Dunning 79

Kentucky Travel Division 135
King's Doughters Clinic 136

Lederle Laboratories 81, 124-125, 134, 137-138, 149
Lilly, Eli & Company 100

McNeil Laboratories 115
Medicol Protective Company 130

National Drug Company 91, 118

Parke, Davis Company 139
Pitman-Moore Company 98-99
Poythress, Wm. P. Company 144

Robins, A. H. Company 78, 119-121
Roche Laboratories 88-89, 152

Searle, G. D. & Company 116-117
Smith, Kline & French 151
Southern Optical Company 145
Stuart Company 92

Warner-Chilcott 141-142
Winthrop Laboratories 95
Wyeth Laboratories 96-97



Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease, warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth, nervousness, insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Spansule® capsules

Trademark. Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

brand of sustained release capsules

Smith Kline & French Laboratories SK&F

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal
(persistent palpitations)



Valium®
(diazepam)

for reliable relief of psychic tension and associated somatic and depressive symptoms (including tension-induced insomnia)... usually well tolerated... 2-mg, 5-mg or 10-mg tablets *t.i.d.* and *h.s.*

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

VOLUME 67 MARCH 1969 NUMBER 3

The Journal of The KENTUCKY Medical Association

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA MAR 21



In This Issue

Fluorescein Retinal Angiography As an Aid in Ocular Diagnosis
William C. Edwards, M.D., John Y. Barbee, Jr., M.D., Roderick Macdonald, Jr., M.D. and Thomas Van Cader 185

Pre- Intra- and Post-Operative Care of the Lung Cancer Patient
Thomas Huth, M.D. 191

Case Report of a Paint-Thinner Sniffer (Enamel Reducer)
Pang L. Man, M.D. 195

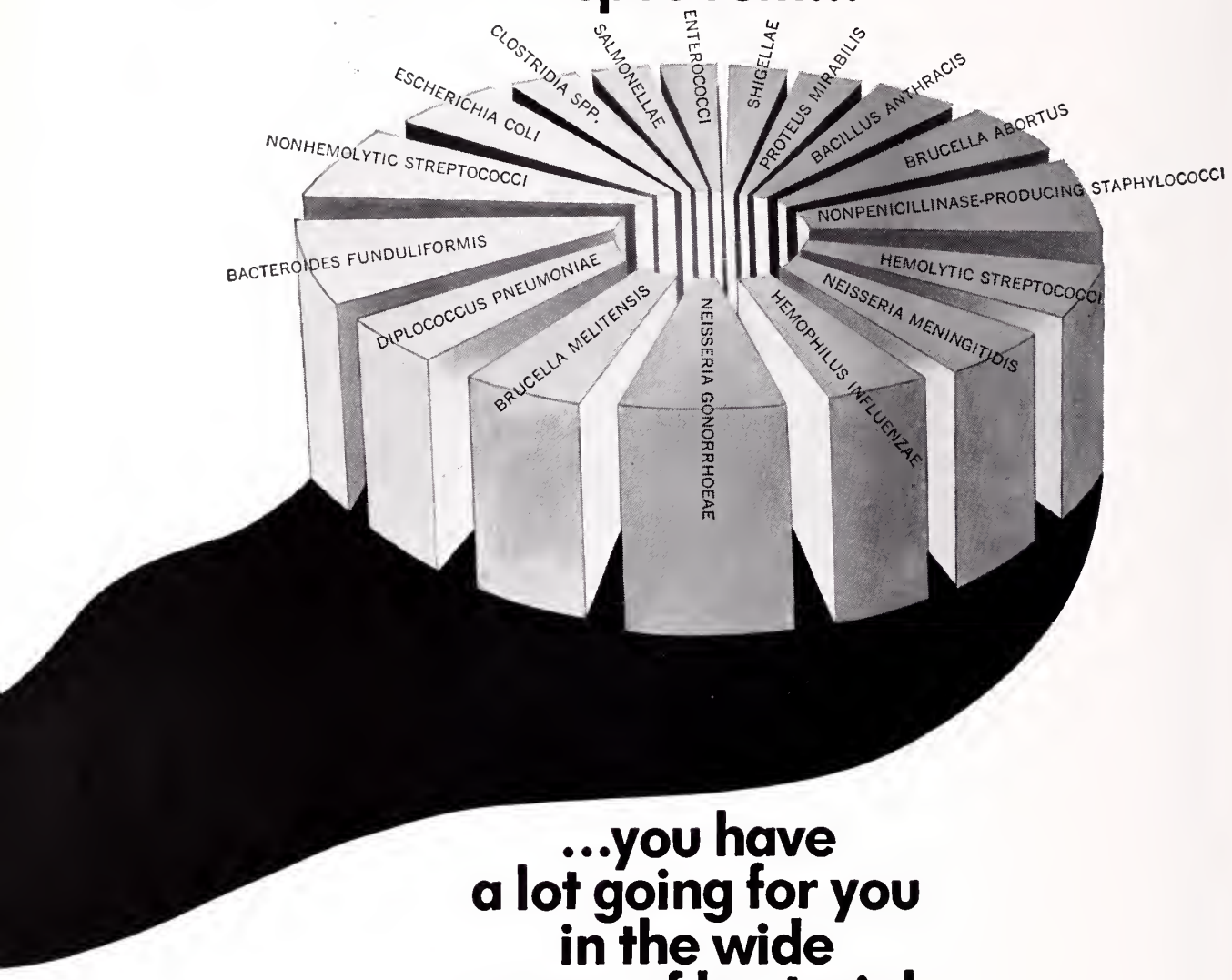
Special Article

Adult Diabetes Mellitus: A Critique of the Diagnosis
James Robert Hendon, M.D. and David White, M.D. 203

Complete Contents on page 156

KMA INTERIM MEETING
March 26-27
Continental Inn—Lexington

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular.
Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.
11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAR 21 1969

LACTINEX®

TABLETS & GRANULES

■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

H&D

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Volume 67 • March 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Peggy Roberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussions
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shroder, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D.
Roy A. Martin, M.D.
Charles R. Perry, M.D.
David C. Shipp, M.D.
John H. Willard, M.D.

Term Expires July 1, 1969
Paul E. Lett, M.D.
David A. Orrihood, M.D.
Harry A. Hamilton, Jr., M.D.
Leslie W. Blakey, M.D.
Raymond J. Timmermon, M.D.
William H. Gillespie, M.D.
J. J. Sonne, M.D.
John L. Creech, Jr., M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10.00—single copy 1.00
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Fluorescein Retinal Angiography As an Aid in Ocular Diagnosis
William C. Edwards, M.D., John Y. Barbee, Jr., M.D., Roderick Macdonald, Jr., M.D. and Thomas Van Cader 185

Pre- Intra- and Post-Operative Care of the Lung Cancer Patient
Thomas Huth, M.D. 191

Case Report of a Paint-Thinner Sniffer (Enamel Reducer)
Pang L. Man, M.D. 195

SPECIAL ARTICLES

Adult Diabetes Mellitus: A Critique of the Diagnosis
James Robert Hendon, M.D. and David White, M.D. 203

EDITORIALS

Health Careers in Kentucky
Joseph Hamburg, M. D. 208

Fair Representation
Sam A. Overstreet, M.D. 208

ORGANIZATION SECTION

KMA Finalizes Plans for 1969 Interim Meeting 217
Six KMA Trustee Districts Plan Spring Meetings 217
Topic of UK Radiology Symposium To Be Bone and Joint Disease ..217
UL, Arthritis Foundation Plan Rheumatic Diseases Conf 217
Mr. Mahoney Joins KMA Staff in Field Services Division 218
Fourth, Seventh KMA Districts Hear Dr. Asman at Meetings 218
Ob-Gyn Society Schedules Mtg. April 11-12 in Louisville 218
Auto Crash Research Program Enters Fifth Phase in Ky 219
County Societies Name Officers for 1969 Associational Year 224

REGULAR FEATURES

President's Page 158
Public Health Page 160
Postgraduate Opportunities ..162
Maternal Mortality Page 172
Insurance Page 174



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



Speaking Out . . . On Chiropractic

LAST month, on this page, we made some rather critical remarks concerning HEW and its former secretary, Wilbur J. Cohen. Seldom in the past have reports, regulations and messages from the Department generated much enthusiasm in medical circles.

Today, however we can express our appreciation to HEW and Mr. Cohen!

Congress, in 1967, directed the secretary to make a study relating to the inclusion of chiropractic, naturopathy, and other independent practitioners under Medicare. The results of this study have now been released, and the Department of HEW has strongly recommended that chiropractic continue to be excluded from this program.

This study was conducted by a blue-ribbon committee chosen "for their lack of bias and their knowledgeability", with technical advice from a panel selected "on the basis of their scientific background and high professional reputations in their respective fields".

Their thorough investigation has led to a damning indictment of the cult of chiropractic, its rejection of the great body of scientific knowledge related to health and disease, its refusal to undertake scientific research, the tragic inadequacies of chiropractic education, and the unscientific basis on which the cult was founded and is practiced.

Further support for the position of Medicine in its long-standing opposition to chiropractic came from the newspaper published by the National Council of Senior Citizens. In its January issue the paper carried a two-page spread headed "Why Chiropractic Cult Cannot Provide Quality Health Care".

Discussing in detail the arguments advanced by Medicine for years in opposition to chiropractic, and emphasizing portions of the well-documented HEW report, this article observes "chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real cause, is at best worthless—and at worst morally dangerous". It concludes by saying "with chiropractic and other unscientific cults, there is no possibility for quality health care".

It might be well if some of our legislators would read these reports before they go to Frankfort next January.

Henry B. Asman

The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS

PUBLIC HEALTH PAGE

Man and His Environment†

RUSSELL E. TEAGUE, M.D., M. P. H.
Commissioner of Health
Commonwealth of Kentucky

RALPH C. PICKARD, B.S.C.E., M. P. H.
Director
Division of Environmental Health

THE Kentucky State Health Department has placed within its Division of Environmental Health most programs that deal with man and his environment. These programs include Environmental Services, Radiological Health, Occupational Health, Plumbing, Sanitary Engineering, Solid Waste, Air Pollution and Water Pollution Control. It is planned over a period of time to examine each of these programs as to its direct relationship to man in his environment. This article is to focus on the

ENVIRONMENTAL SERVICES PROGRAM

Happiness of man in his environment cannot be complete unless he has readily accessible a clean, wholesome, safe food supply, a clean place to play, and a clean comfortable place to sleep. Laws and regulations administered through the Environmental Services Program play a very important role in this phase of man living in his environment.

For effective administration the Environmental Services Program has been divided into three large operating units:

a. Food Manufacturing

Through adequate periodic inspections of food manufacturing and processing plants and food storage warehouses the Environmental Services Program protects the consumer from adulterated, falsely advertised and misbranded food products.

A trained staff inspects bakeries, soft drink bottling plants, flour mills, grain elevators, canneries, candy kitchens, wholesale groceries, food storage warehouses and general food processing plants. In addition to the inspector's visual observations of an establishment's facilities and good manufacturing practices as related to wholesomeness of the product, he also determines correct product labeling, and collects samples for chemical and microbial laboratory analysis which may reveal product contamination.

Quite recently a cooperative agreement has been entered into with the Food and Drug Administration which is designed to provide mutual training for state and federal inspectors, prevent duplication of effort by the federal and state agencies involved and still further broaden the field of protection afforded the consumer through the possibility of purchase of an adulterated, falsely advertised and/or misbranded product.

b. Milk Control

Milk control consists of control programs from the farm to the consumer. The state of Kentucky ranks 15th in the nation in milk production, processing and sales—a hundred million dollar industry consisting of some 28,000 grade A and milk for manufacturing producers, and 87 milk processing plants and receiving stations.

Milk and milk products are an excellent source of nutrients for man in his environment. Unfortunately, many diary products also provide an excellent source of nutrients for growth of harmful bacteria if they are unprotected or mishandled. In order that milk and milk products may be free from any harmful disease producing organisms, many preventative practices must be carried out. Some of these practices include farm inspection, plant inspection and sample collection of both raw and finished product.

In order for these products to move freely in interstate commerce certification as to their wholesomeness and sanitary production must be made to those states wherein they are to be sold. This certification is carried out under a cooperative agreement between the United States Public Health Service and participating states and is known as the Interstate Milk

†*This article was prepared by Shelby Johnson, B.S., M.P.H., Director, Environmental Services Program, Division of Environmental Health, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky 40601*

Shippers Conference Agreements. Only those supplies that meet the rigid requirements of the Interstate Milk Shippers Conference Agreements are allowed to bear the "Grade A" label, the universal emblem of a safe, wholesome top quality milk and milk product.

c. General Sanitation

The popularity of mobile home living has greatly increased in recent years. The Environmental Services Program working through local health departments has programs designed to provide an environment conducive to pleasant living and the prevention of communicable diseases that are associated with unsanitary surroundings, unapproved water supplies, sewage disposal and garbage collections systems. The program is built around submission of plans, inspection of facilities, issuance of permits and legal action against trailer coach parks not operating in compliance with the law.

The Environmental Services Program on a specific grant received from the U. S. Public Health Service recently instituted a two-year study of pesticide usage in Kentucky. The study is designed to evaluate the acute effects of pesticide usage on man in his environment. Study activities will focus on the development of pesticide usage profile, pesticide morbidity and mortality, empty pesticide container disposal and, human and air monitoring in specific areas of the state. A comprehensive review will be made of all state and local laws applicable to pesticide usage, registration, etc. A three-day training session will be designed and made available to appropriate public health personnel during the first year of the study.

The food and beverage industry ranks fourth in size among all industries of the nation. The popularity of eating out and the change of eating habits of man inside his home have brought about new problems in food protection. These problems are in relation to production, processing, transporting and serving a multitude of new types of foods such as convenience-type foods, heat-and-eat meals, etc. Increased roles must be assumed by industry processing these foods and the public health agency in monitoring preparation, storage, and serving of these foods if the consumer is to be insured a safe, wholesome food and drink supply.

Kentucky has some 10,000 private, public and state food service establishments that serve some two million meals per day. Most of these meals, if not produced, handled, stored and served under good sanitary conditions, may become a potential vehicle for the transmission of bacterial agents capable of producing food intoxication or food poisoning. The major responsibility of all concerned is to operate all food service establishments and facilities in such a manner as to prevent the spread of disease through food media.

Prior to late 1968 there was no uniform food service code in Kentucky. In November of that year the Kentucky State Board of Health adopted a uniform food service code based on the 1962 recommended Food Service Code of the U.S. Public Health Service and a uniform food service program is now in the process of being planned to be implemented when the Code becomes effective July 1, 1969.

The program as planned will include inspections, reinspections of food service establishments, sample collection of suspected adulterated food products and an enforcement program against violators.

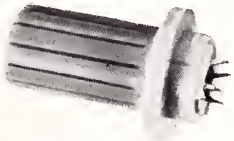
To prevent possible spread of diseases communicable to man in other areas of his environment the Environmental Services Program has educational and regulatory control programs in school sanitation, hotel and motel sanitation, septic tank cleaners' regulation and recreational sanitation.

EMERGENCY ROOM PHYSICIAN

Accredited 280 bed progressive general hospital. Guaranteed annual income. Immediately available. Contact Administrator, Cabell Huntington Hospital, 1340 16th St., Huntington, West Virginia.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

APRIL

1-4 Student American Medical Association National Convention, Conrad Hilton Hotel, Chicago, Ill.

3 Fourteenth Annual Clinical Conference, Lexington Clinic, Lexington

10 Fifth Annual Rheumatic Disease Symposium, "What's New in Rheumatic Diseases," Rankin Amphitheater, Louisville General Hospital, Louisville

11-12 Kentucky Obstetrical and Gynecological Society Annual Spring Meeting, Stouffer's Inn, Louisville

18-19 Continuing Education Course, "Practical Exercises in Neurology, Neuro-surgery and Neuro-opthalmology," University of Kentucky College of Medicine, Lexington

25-26 Continuing Education Course, "A Seminar on Laboratory Management," University of Kentucky College of Medicine, Lexington

29-May 2 "Current Concepts in Bone and Joint Disease," Symposium, University of Kentucky Medical Center, Lexington

MAY

16-18 Kentucky State Association of Medical Assistants Seventh Annual Convention, Holiday Inn, Elizabethtown

IN SURROUNDING STATES

APRIL

10 Kentucky Society of Pathologists Annual Spring Meeting, Cincinnati Academy of Medicine, Cincinnati, Ohio

16-17 Postgraduate Course, "Symposium on Rheumatic Disease," Cleveland Clinic Educational Foundation, Cleveland, Ohio

16-19 Thirteenth Annual Postgraduate Course in Trauma, Chicago Committee on Trauma of the American College of Surgeons, John B. Murphy Memorial Auditorium, Chicago, Ill.

21-23 American Academy of Pediatrics Annual Spring Session, Sheraton-Boston Hotel, Boston, Mass.

24-26 American Academy of Physical Medicine and Rehabilitation 31st Annual Session, Sheraton-Chicago Hotel, Chicago, Ill.

26-27 Twenty-first Annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology, University of Cincinnati College of Medicine, Cincinnati, Ohio

28-May 1 Seventeenth Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla.

MAY

8-10 Postgraduate Course in Pediatrics, University of Cincinnati Department of Pediatrics, Cincinnati, Ohio

8-10 National Conference on Breast Cancer, Shoreham Hotel, Washington, D.C.

14-16 National Society for the Prevention of Blindness, Inc., Annual Conference, Pfister Hotel, Milwaukee, Wisconsin

SEND IN MEETING INFORMATION

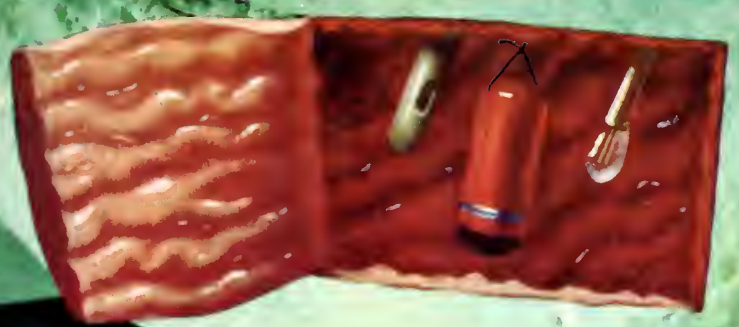
Many medical organizations are setting dates for their spring and fall meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

the inside story of a new antacid formulation...

with consistent buffering you can measure



consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Warner-Chilcott Laboratories Division.

introducing new

GELUSIL®-M

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate, 250 mg. aluminum hydroxide (Warner-Chilcott), 200 mg. magnesium hydroxide
U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

† Avoids constipation.

See next page for prescribing information ►

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey

GM-IN-93-4C

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

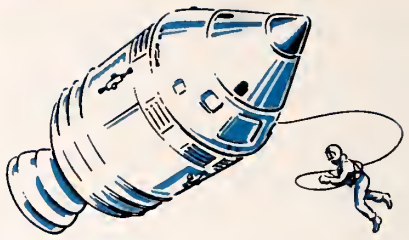
ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



"The inconvenience of a cold"

a cold, NTz® Nasal Spray provides rapid relief of
al symptoms. Relief starts with the first spray which
ens the inferior part of the common meatus. A second
ay, a few minutes later, will shrink the turbinates to
p provide sinus drainage and ventilation. Dosage
y be repeated every three or four hours as needed,
temporary relief of symptoms. NTz is well tolerated
overdosage should be avoided.

a sinusitis deterrent, NTz Nasal Spray can be used to
ep the nasal passages open during a cold to help pre-
nt development of acute sinusitis—or to help prevent
acute condition from becoming chronic.

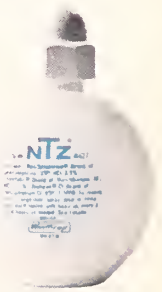
pplied: NTz Nasal Spray, plastic squeeze bottles of
ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.)
th dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

ANTISECRETORY SEDATIVE

Antrocol

Antrocol provides the prompt, predictable antisecr tory action of the belladonna alkaloid, atropine, fort fied with sedation and blended with Bensulfoid, co tributing to slow, even absorption.

Each Antrocol tablet or capsule contains 0.324 mg. atropine sulfate, which is twenty-four thousandths a milligram more than the smallest effective do specified in U.S.P., Vol. 17. This slight increase in t smallest effective dose of the antisecretory fact (atropine) is all the average patient can tolera without discomfort.

One Antrocol tablet or capsule taken three tim daily lessens emotional stress and maintains a gastr function that is not conducive to the development peptic ulcer.

Antrocol is also useful in the treatment of pept ulcer. Dosage up to 8 tablets or capsules per day obtain the desired antisecretory titer. When ulcer h healed, one Antrocol tablet or capsule morning a evening gives protection against recurrence.

Each tablet or capsule contains:

Atropine Sulfate	0.324 mg.
Phenobarbital (may be habit forming) ..	16 mg.
Bensulfoid, see white section P.D.R. ...	65 mg.

Side-effects: Toxic levels of atropine may produce flushing, dry mouth, blurred vision, tachycardia, or urinary retention. Precautions: Do not use in glaucoma. Use cautiously in prostatic hypertrophy.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & CO., IN
RICHMOND, VIRGINIA 232
Manufacturers of ethical pharmaceuticals since 1

Antrocol®

ANTISECRETORY
SEDATIVE

POST-GRADUATE SYMPOSIUM ON RHEUMATIC DISEASES

Rankin Amphitheater **APRIL 10, 1969** Louisville General Hospital

SPONSORED BY THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE AND THE KENTUCKY ARTHRITIS FOUNDATION

TOPIC: "WHAT'S NEW" IN RHEUMATIC DISEASES

This symposium will emphasize emerging knowledge and concepts concerning immunology and underlying mechanisms of arthritis and inflammation. Clinical application of recent advances, of both medical and surgical interest, will be stressed. Major topics to be discussed include rheumatoid arthritis, rheumatoid arthritis in children, osteoarthritis, crystal induced synovitis, arthritis of a periodic and intermittent nature, and surgical approaches to arthritis. Panel discussions with audience participation will follow the morning and afternoon presentations.

GUEST FACULTY:

ALFRED J. BOLLET, M.D. Augusta, Georgia	*Current comment on Pathogenesis and Treatment of Osteoarthritis*
JOHN J. CALABRO, M.D. Los Angeles, California	*Juvenile Rheumatoid Arthritis: Newer Knowledge*
GEORGE E. EHRLICH, M.D. Philadelphia, Pennsylvania	*Periodic and Intermittent Arthritis.*
J. WILLIAM HOLLINGSWORTH, M.D. Lexington, Kentucky	*Cellular Immunology with possible implications in Rheumatoid Arthritis*
ROLAND W. MOSKOWITZ, M.D. Cleveland, Ohio	*Mechanisms of Inflammation in Arthritis: Clinical Relevance.*
HOWARD F. POLLEY, M.D. Rochester, Minnesota	*Current Comments on Diagnosis and Management of R.A.*
ROBERT L. PRESTON, M.D. New York, New York	*Advances in Orthopedic Management of Rheumatic Diseases.*

U. OF L. FACULTY:

Frank W. Lehn, M.D. David H. Neustadt, M.D. Donn L. Smith, M.D. Beverly T. Towery, M.D.

NO REGISTRATION FEE **LUNCHEON FEE $3.50**

Approved for six prescribed hours by American Academy of General Practice

FOR FURTHER INFORMATION CONTACT KENTUCKY ARTHRITIS FOUNDATION, 1381 BARDSTOWN RD., LOUISVILLE, KY. 40204



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Medical Economics says:
GENERAL LEASING'S PLAN IS
"The Winning Way"
TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ Leasing better than buying
- ★ No capital investment
- ★ Dependable car at all times
- ★ Certain tax advantages
- ★ Call us for particulars

LEASE
Medical or Surgical
EQUIPMENT

- ★ A plan for young doctors
- ★ Medical and Surgical equipment
- ★ Complete office furnishings
- ★ Enlarging facilities
- ★ Call us for full details

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 10-67. This 25 year old married colored, gravida V, para IV was admitted to the hospital on June 2 at 7:45 p.m. with a history of ruptured membranes, having been seen by her physician just prior to admission. Her past history was as follows. Seven years before, she was admitted to the same hospital with a complaint of profuse uterine bleeding of several weeks' duration. Vaginal examination at that time showed blood clots in the vagina, but no other masses and the impression was possible incomplete abortion or hyperplasia of the endometrium. A curettage was performed and yielded only secretory endometrium. She had undergone curettage at the same hospital two years before for a suspected incomplete abortion, but microscopic report showed only fragments of proliferative endometrium with no chorionic villi or decidual tissue.

Examination at 8:15 p.m. showed a fetus in vertex presentation with the presenting part at station -3. The cervix was long and thick, and dilated to 1 cm; there was some leakage of amniotic fluid. The uterine contractions were irregular. The fetal heart rate was 142. The patient's blood pressure was 110/70. She slept all night under mild sedation with Nembutal. On the morning of June 3, she was experiencing mild contractions. A plain film of the abdomen showed a single fetus at or near term in vertex presentation, R.O.T. The head was at the pelvic inlet in films taken with the mother in both recumbent and upright positions. There was no displacement of the head in either anteroposterior or lateral projections. The pelvis was gynecoid with ample measurements in all directions. The impression was a single fetus at or near term in vertex presentation without x-ray evidence of cephalopelvic disproportion. The radiologist stated that the failure of the fetus to descend into the pelvic canal was suggestive of placenta previa or a short umbilical cord.

The patient received intravenous Pitocin stimulation on June 3, 1 cc in the form of an infusion of 1,000 cc of 5% glucose in water without any response. On June 4, she was still comfortable. Examination showed no change, so it was thought that she was not in labor and was discharged. Her temperature was 99.4°; the fetal heart was of good quality and counted at 132 in the right lower quadrant. The blood pressure was 110/88. She was complaining of some pressure in her lower abdomen, but had only mild irregular contractions on discharge.

The patient was re-admitted on June 8 at 12:10 a.m. complaining of pain in her right side. She appeared acutely ill. Her temperature was 101°, pulse 54, respirations 14, and blood pressure 60/30. She was given 50 mg of Demerol intramuscularly and 1,000 cc of 5% dextrose in water was started intravenously. At 12:20 a.m. she received one unit of adrenalin and at 12:23 a.m., 400,000 units of penicillin were given intramuscularly. She was examined at 12:30 a.m. and some foul smelling blood clots were encountered in the vagina. The patient was restless and it was difficult to keep the intravenous infusion running; it infiltrated and artificial respiration was necessary. She became cyanotic and her pupils dilated. At 1:38 a.m., she was perspiring freely and oxygen was started. Despite these measures she ceased to breathe and died at 1:38 a.m.

At autopsy, the abdominal cavity was distended with 3 to 4 liters of blood and amniotic fluid together with a 7 pound female fetus. The uterus showed a linear rupture extending from the top of the fundus down the entire left side of the lower uterine segment. The cervix was dilated to 4 cm and there was no cervical or lower uterine obstruction. The placanta separated easily from the uterine lining and was not abnormal. The area of separation measured 15 X 15 cm of the uterine lining. Microscopic examination of the uterus showed a purulent exudate, and active interstitial inflammation in the myometrium, expecially in the region of the tear. The final diagnoses were: (1) spontaneous rupture of the uterus; (2) suppurative endometritis and myometritis; (3) massive hemoperitoneum; and (4) term pregnancy.



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories



THE INSURANCE PAGE



Medicine Benefits from Claims Review

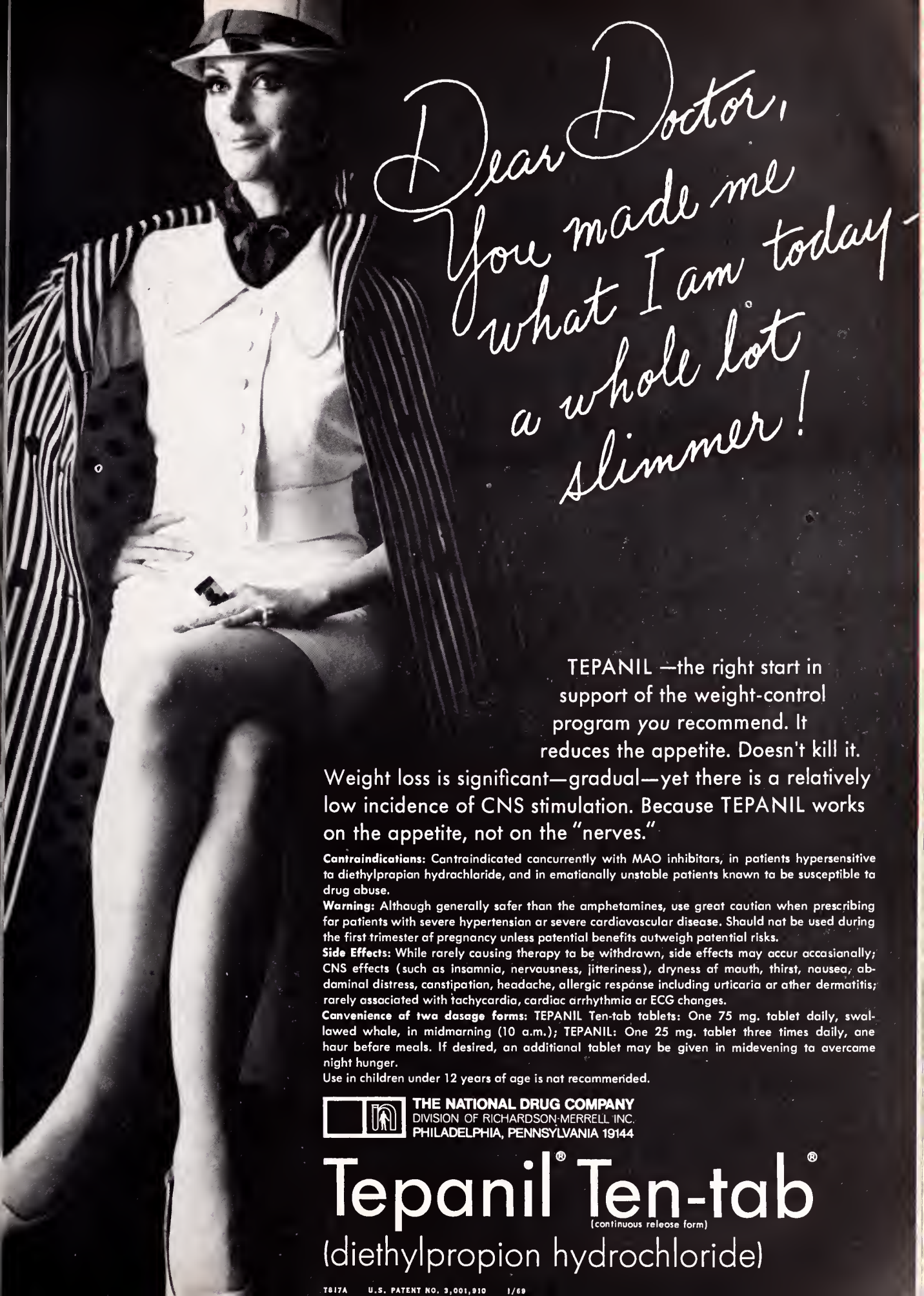
THE DEMAND for paid in full medical insurance coverage has been growing rapidly in the last few years. This demand has been accelerated by the advent of Medicare and Medicaid and the adoption by large national employers of the usual and customary fee principle. This principle of fee payment is enthusiastically endorsed by the medical profession, not only in Kentucky, but all over the nation.

Blue Shield with the support of the Kentucky Medical Association has developed a Usual and Customary program which, as of January 1, 1969, covers more than 300,000 Kentuckians. The Usual and Customary program is a great advance in medical prepayment, but it has a major weakness; it can be exploited to create larger bills by overutilization or by overcharging. The KMA House of Delegates, recognizing this, adopted a resolution providing for professional review of claims by physicians in county claims review committees across the state. The resolution also provides for a KMA statewide committee, representing all specialty groups, to consider cases from counties too small to have local committees, and also difficult or complicated cases referred from larger county societies.

The KMA Claims Review Committee held its first meeting on November 21, 1968 and adopted guidelines to be used in the administration of the program. A claim will not be accepted for review until a reasonable attempt has been made, by the carrier, to settle the problem with the attending physician. When a claim is incomplete, or if the fee submitted is beyond the level of routine payment, a letter will be sent to the attending doctor requesting information on the complexities of the case and whether complications occurred which would justify an unusual fee. When this additional information is received the case is reconsidered and may, at this point, be paid. If however, the claim is still not resolved, the physician will be personally contacted by a Professional Relations Representative of Blue Shield in order to seek additional information, to explain and discuss the mechanisms of the program, and explain the referral of the case to a committee of physicians for review.

The formation of peer review committees is an important and progressive step for the Kentucky Medical Association, because the question of medical care costs has become too complicated and too crucial for the medical profession to leave to others. Doctors must enter fully into the vital problem of costs, since the alternative is to let the whole idea of comprehensive prepayment go by default and allow further government intrusions.

WILLIAM W. HALL, M.D.



TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicated concurrently with MAO inhibitors, in patients hypersensitive to diethylpropion hydrochloride, and in emotionally unstable patients known to be susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use great caution when prescribing for patients with severe hypertension or severe cardiovascular disease. Should not be used during the first trimester of pregnancy unless potential benefits outweigh potential risks.

Side Effects: While rarely causing therapy to be withdrawn, side effects may occur occasionally; CNS effects (such as insomnia, nervousness, jitteriness), dryness of mouth, thirst, nausea, abdominal distress, constipation, headache, allergic response including urticaria or other dermatitis; rarely associated with tachycardia, cardiac arrhythmia or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger.

Use in children under 12 years of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

T617A U.S. PATENT NO. 3,001,910 1/69

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

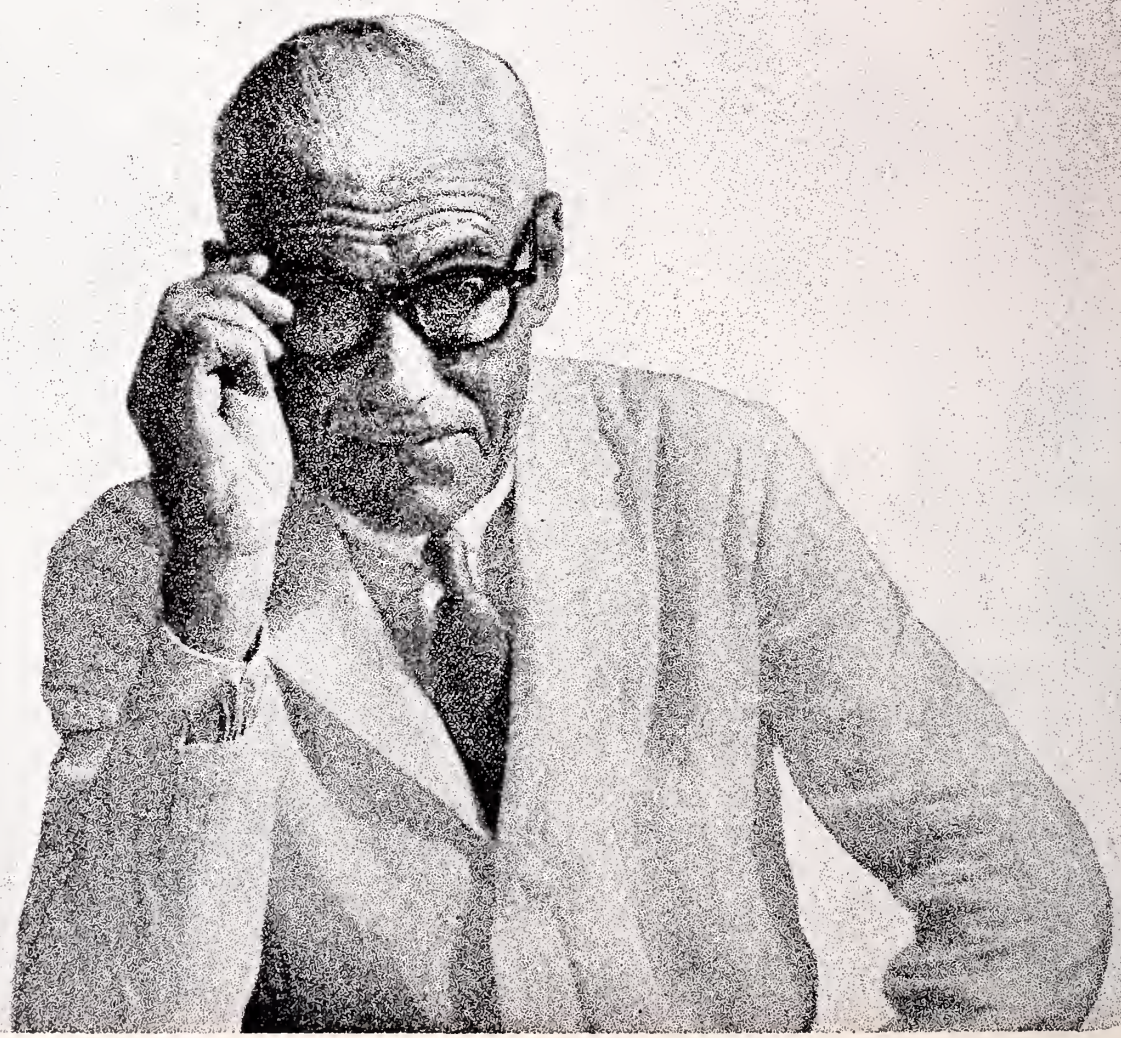
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®





Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Agroun

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm ... tially capsized. The fire depa... had to rescue Waters by smal... Damage to the yacht is estim...

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

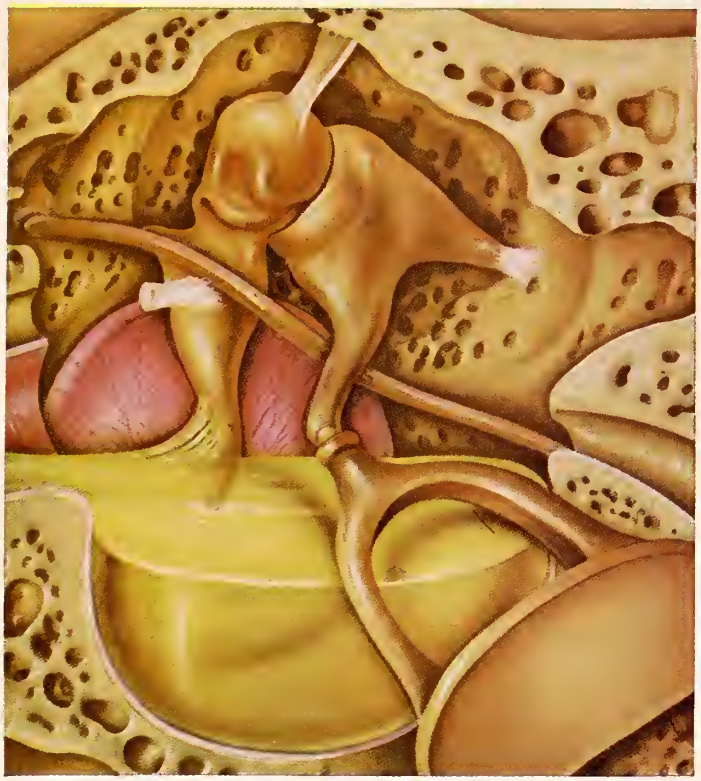


See next page for prescribing information



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, th most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strai may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged acti permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocoli pruritus ani. Skin—maculopapular and erythematous rashes; a r case of exfoliative dermatitis has been reported. Photosensitivi onycholysis and discoloration of the nails (rare). Kidney—rise in BU apparently dose-related. Transient increase in urinary output, son times accompanied by thirst (rare). Hypersensitivity reactions—u caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (y low-brown) in children of mothers given this drug during the latter h of pregnancy, and in children given the drug during the neonatal pe od, infancy and early childhood. Enamel hypoplasia has been seen a few children. If adverse reaction or idiosyncrasy occurs, discontin medication and institute appropriate therapy. Demethylchlortet cycline may form a stable calcium complex in any bone-forming tiss with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shou be given 1 hour before or 2 hours after meals, since absorption impaired by the concomitant administration of high calcium conte drugs, foods and some dairy products. Treatment of streptococc infections should continue for 10 days, even though symptoms ha subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 3 mg, 150 mg and 75 mg of demethylchlortet cycline HCl.

39

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

now she can cope...



hanks to

Butisol SODIUM®

(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

is a tablet that begins to relieve
ptoms of upper respiratory infec-
quickly—a tablet that works for
s to make it easy for your patient
njoy continuous relief.
ahistine Singlet combines effective
ge of an antipyretic-analgesic
a vasoconstrictor-antihistamine
ulation to relieve not only the
jestion, but also the fever and
ches and pains that almost always
mpany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful).

[042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 MARCH, 1969 No. 3

Fluorescein Retinal Angiography As an Aid in Ocular Diagnosis

WILLIAM C. EDWARDS, M.D., JOHN Y. BARBEE, JR., M.D.
RODERICK MACDONALD, JR., M.D. AND THOMAS VAN CADER

Louisville, Kentucky

Fluorescein angiography has proven to be of great benefit as a diagnostic technique in many ocular diseases. Illustrative cases show how this test aids the ophthalmologist. This technique has led to an improvement in current concepts regarding the pathogenesis of certain diseases of the ocular fundus.

FLUORESCEIN retinal angiography is an important adjunct in ophthalmologic diagnosis and treatment. This technique, first described by Novotny and Alvis[1] in 1961, has undergone various modifications. Present regimes generally follow that of Scott, et al[2], using the equipment modifications described by Hodge and Clemett[3]. The entire study requires about 90 minutes.

Method

Following dilatation of the pupils, aqueous sodium fluorescein dye* (10 c.c.) is injected into the antecubital vein while the patient's head is positioned at the Zeiss fundus camera. Initial retinal photographs are taken prior to dye injection. Then serial fundus photographs are taken at intervals for approximately one hour. Few toxic reactions to the dye have been reported[4], only one of which was serious[5]. In a series of 328 fluorescein retinal studies performed in the department of ophthalmology of the University of Louisville School of Medicine, the complications have been as follows: three episodes of brief syncope, one case of hives and one case of generalized pruritus without hives.

The following events occur in a normal fluorescein study[1]. After injection into the antecubital vein, there is a delay of 8-15 seconds before the fluorescein reaches the eye. The initial change recorded photographically is a mottled fluorescence of the retinal background or "choroidal flush". The macula appears as a dark area because of increased pigment epithelium thickness. Almost simultaneously, with the choroidal phase, the dye begins to appear in the retinal arteries; the "arterial phase". Dye then gradually appears in the veins in a laminar flow pattern. This is the "arterio-venous phase", an example of which is seen in Figure 1. Following this, dye begins to disappear from the arteries and only the veins fluoresce brightly, marking the "venous phase." After several minutes all of the fluorescence fades. By the end of an hour the studies will approach the pre-injection status (control).

Altered patterns of fluorescence are seen in many pathologic states. If there is a leak of serum into the retina from choroidal abnormalities or retinal vascular abnormalities, a bright

*Fluorescite 5% T.M.
Moore and Kirk Lab

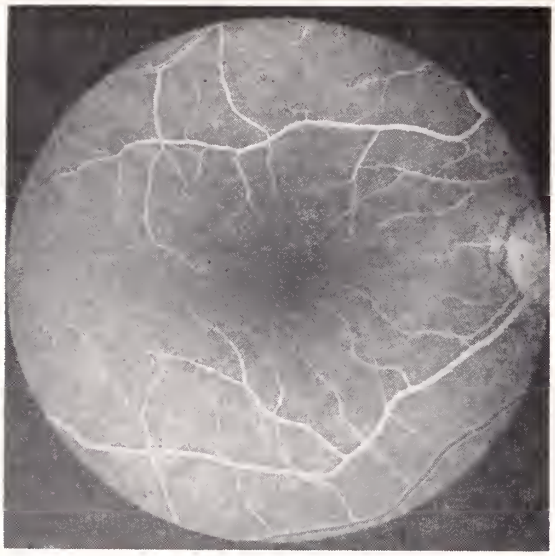


FIGURE 1. Arterio-venous phase of normal fluorescein fundus study. Note the retinal arteries (solid white vessels), retinal veins (laminated vessels), disc at right, and dark appearing macular area in the center.

flourescing spot appears. Extracellular fluid, as a result of this leak, spreads out causing a diffuse fluorescing area. Thinning or atrophy of the retinal pigment epithelium will produce a fluorescence corresponding to the defect. Other abnormalities may include aberant vascular patterns such as seen in tumor formation.

Discussion

Table 1 gives a summary of 328 cases studied in the department of ophthalmology. The cases are subdivided into several categories to illustrate the diversity of conditions currently being studied by this technique. The following disease states emphasize the value of fluorescein angiography as a clinical diagnostic tool.

1. MALIGNANT MELANOMA

One classic diagnostic problem in ophthalmology is the dark-appearing or pigmented lesion of the fundus. Among the possible diagnoses are included malignant melanoma, benign nevus, and hemorrhagic detachment of the retinal pigment epithelium. Figure 2 shows the fluorescein findings in a 43-year-old white male taken late in the arterial-venous phase. This patient was examined by two ophthalmologists in a period of three months with a complaint of decreased vision. The examinations were negative. Later a dark, solid retinal detachment with a retinal hole developed. The fluorescein study showed numerous deep sub-

TABLE ONE

FLUORESCEIN RETINAL ANGIOGRAPHY MAJOR DIAGNOSTIC CATEGORIES

1. Pigmented Lesions		
Nevus	19	
Melanoma	20	
Metastatic tumor	2	
		41
2. Macular Lesions		
Macular degeneration	33	
Central Serous retinopathy or "choroidopathy"	17	
"Hemorrhagic" "Disciform" degen.	15	
Irvine's Syndrome	13	
Undetermined	11	
Edematous	11	
Macular cyst	8	
		123
3. Diabetic Retinopathy		10
4. Vascular Anomalies		
Hemangioma	6	
Von Hipple Lindau	2	
		8
5. Mesodermal Anomalies		
Angioid Streaks	5	5
6. Uveitis		
Histoplasmosis	44	
Toxoplasmosis	8	
Syphilis	7	
Other	7	
		66
7. Miscellaneous		
Normal	24	
Undetermined	24	
Vascular	7	
Occlusion	4	
Papilledema	5	
Multiple Sclerosis	1	
Papillitis	3	
Nematode	2	
Drusen	3	
Choroidal atrophy	2	
Retinal hole	1	
Retinitis pigmentosa	1	
Grouped pigment	1	
Pale disc	1	
Chloroquin retinopathy	1	
Optic atrophy	1	
Myelinated nerve	1	
		82

retinal vascular channels with late fluorescein dye pooling. This finding is compatible with choroidal tumor growths. Following enucleation, a malignant melanoma was found on pathological examination.

2. BENIGN PIGMENTED LESIONS

Figure 3 shows the findings in a 27-year-old white female. This patient was discovered by her internist to have a dark pigmented lesion in one fundus. Fluorescein angiography re-



FIGURE 2. Solid detachment of retina due to choroidal melanoma. Note the network of vascular channels appearing in early arterial phase beneath the retina (slightly "out-of-focus" because of their depth).

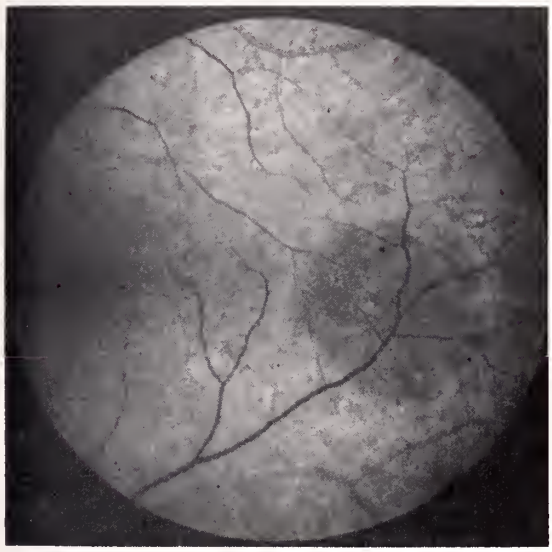


FIGURE 3. Choroidal nevus; dark circular area where choroidal flush is partially obscured.

vealed a blocking of the choroidal flush without the presence of an abnormal vascular pattern or fluorescein staining in late photos. The diagnosis was thought to be a choroidal nevus. Two-year follow-up has revealed no change in the lesion. A hemorrhagic detachment of the retinal pigment epithelium may appear similar to a nevus but usually has more rounded borders and marginal fluorescence of dye.

3. CHOROIDAL HEMANGIOMA

Vascular malformations, such as hemangioma, can be confused with a malignant melanoma or a metastatic tumor of the choroid. Reese[6] states that this diagnosis is one that is seldom correctly made in the absence of evidence of hemangiomas elsewhere. Figure 4 shows the fluorescein findings in a 19-year-old white female who was first seen as a contact lens patient. Examination revealed that she had had poor vision all of her life in her left eye. Previously, a diagnosis of old chorioretinitis was made. Visual acuity at the time of the present examination was 20/15 O.D. and hand motion O.S. Ophthalmoscopic examination of the left eye revealed a flat gray detachment of the retina around the disc. The macula had many old exudates and one area of chorioretinal scarring. In the periphery there was a ring of waxy yellow-white exudates. Fluorescein study showed a large number of abnormal vessels appearing early in the arterial phase about the disc. (Figure 4) Early diffuse fluorescence due to fluorescein leakage from the hemangioma is also present. These studies are compatible with previous reports of choroidal hemangioma[7,8]. Metastatic tumors sometimes show abnormal vascular patterns and about one-half of them[9] show fluorescein staining in late photographs. History and observation of the lesion are usually necessary in the differentiation of metastatic choroidal tumors.

4. DIABETIC RETINOPATHY

Fluorescein angiography may be helpful in evaluating diabetic retinopathy[10,11]. As seen in the control photograph, Figure 5, there is dilatation of retinal veins, dot and blot hemorrhages, hard exudates near the disc, and be-

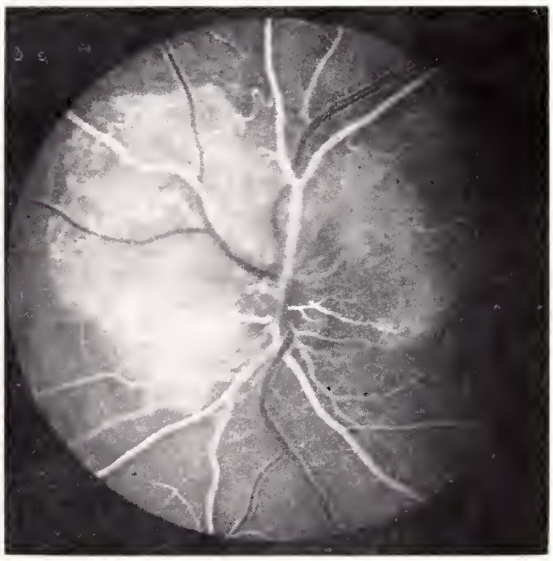


FIGURE 4. Choroidal hemangioma.

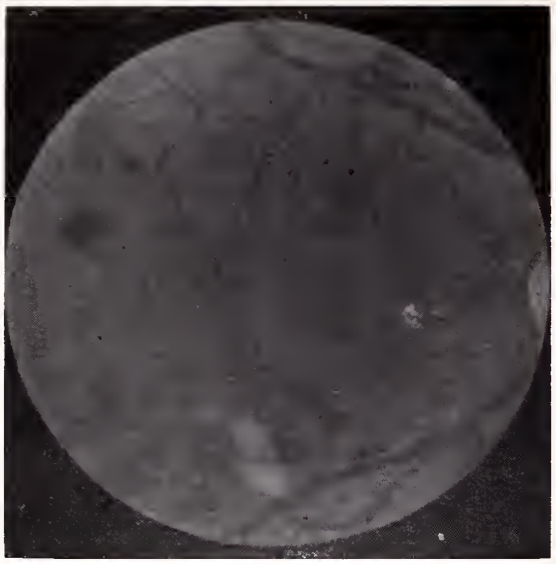


FIGURE 5. Diabetic retinopathy, prior to injection of dye.

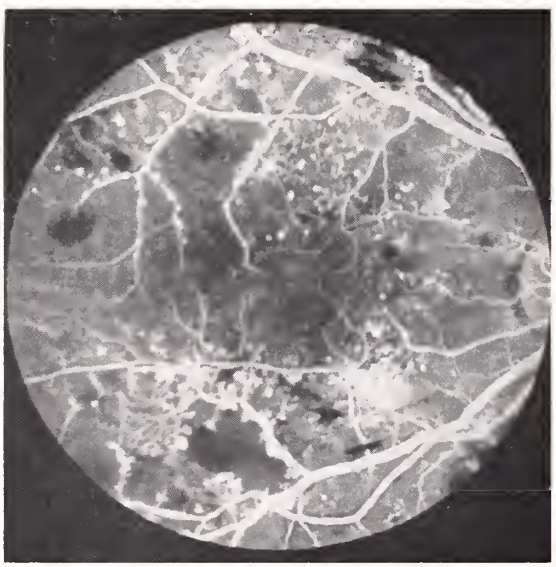


FIGURE 6. Diabetic retinopathy, same case as Figure 6, following injection of dye. Note numerous microaneurysms and areas of surface retinal neovascularization.

low the macula there is an area of edema. These photographs are from a 37-year-old white female juvenile diabetic.

Following fluorescein injection, Figure 6, the full extent of the retinal disease becomes evident. Numerous microaneurysms and hemorrhages can be seen that were not apparent on the control photo. Wide spread retinal edema can be seen as well as neovascularization. Thus, fluorescein angiography can be used to assess the extent of diabetic retinopathy, and may prove helpful when a retinal photocoagulation therapy is contemplated.

5. ANGIOID STREAKS

Degeneration and breaks in Bruch's membrane which lies between the retina and choroid may result in visual loss. These breaks, occuring in linear fashion, are referred to as "angiod streaks". Fluorescein angiography may high-light these areas[12]. Figure 7 shows the findings in a 49-year-old white male with pseudoxanthoma elasticum. Retinal degeneration is beginning, secondary to disease of the underlying collagenous (Bruch's) membrane.

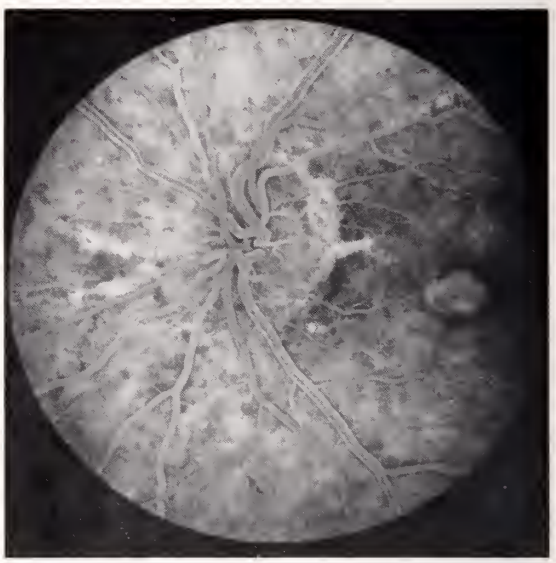


FIGURE 7. Angioid streaks radiating away from disc towards macula.

6. PAPILLEDEMA AND PSEUDOPAPILLEDEMA

Edematous states of the optic nerve heads may be difficult to evaluate in their early stages. Fluorescein fundus photography has been used to study papillitis and papilledema in an attempt to differentiate these conditions from "pseudopapilledema"[13]. Figure 8 is a fluorescein study from a 27-year-old white male with papilledema. Fluorescein staining is seen in the peripapillary retina. The disc tends to fluoresce for a longer period of time than is seen in the normal studies.

7. VISUAL LOSS FOLLOWING CATARACT SURGERY

"Irvine's Syndrome" or "cystoid macular edema" which occurs in aphakic eyes a variable length of time after cataract extraction results in a diminution of visual acuity[14]. Although the cause is not definitely known, it may be due to vitreous traction in the macular area of the retina. In some cases, the retinal changes may not be observable by the



FIGURE 8. Fluorescence of optic nerve head in edematous state.

usual techniques of fundus examination. In almost all instances, however, fluoreseein angiography demonstrates a eharaeteristie pattern of maeular fluoreseenee whieh is illustrated in Figure 9. This photograph is from a 65-year-old white female who had a marked deerease in visual aeuity approximately two months following eataraet extraetion.

8. MACULAR DISEASE AND "CHOROIDAL LEAKS"

Fluoreseein angiography has been widely used to study diseases of the maeular area of the retina[14]. By observing the appearanee of dye in the posterior pole of the fundus and noting the time intervals at whieh it disappears, a better understanding of the nature of these diseases has been obtained. "Serous retinopathy" or "serous ehoroidopathy" usually oeeurs in early adulthood and is aeeompanied by metamorphopsia and deereasing visual aeuity. The ehanges may be transient and self-limiting, reeurrent, or progressive. It is thought to begin with a small foeal detaehment of the retinal pigment epithelium by edema fluid. This may diffuse under the retina, eausing the eireular elevation of the maeula noted elinieally. Figure 10 shows the fluoreseein fundus photograph from a 30-year-old white male with sudden onset of deereased visual aeuity in one eye that persisted for six weeks before



FIGURE 10. "Central serous choroidopathy" or retinopathy showing focal leak of dye (small white spot) in macular area.



FIGURE 9. Characteristic "floriform" pattern of macular edema following lens extraction.

elearing. There is a small diserete ehoroidal "leak" of fluoreseein in the nasal part of the maeula. In a later photograph, Figure 11, it ean be seen that this fluoreseein has diffused out under a larger area of the retina and delineates the full extent of the fluid elevation in this area. If this eondition persists, it may be treated by photoeoagulation. The fluoreseein study indieates the preeise area to apply the photoeoagulation.

9. UVEITIS

In posterior ehorioretinitis fluoreseein angiography may be an aid in determining the extent of the disease. It has also been used to evaluate the effeetiveness of therapy and to indieate the state of aetivity of the inflammatory proeess.



FIGURE 11. Late photo of Figure 10 showing faint diffuse staining of subretinal fluid in area of circular macular elevation.

Summary

Fluorescein angiography has proven to be of great benefit as a diagnostic technique in many ocular diseases. Illustrative cases show how this test aids the ophthalmologist. This technique has led to an improvement in current concepts regarding the pathogenesis of certain diseases of the ocular fundus.

Bibliography

1. Novotny, H. R.: and Alvis, D. L.: A Method of Photographing Fluorescein in Circulating Blood in the Human Retina, *Circulation 24:* 82-86, July 1961.
2. Scott, D. J.; Dollery, C. T., Hill, D. W.; Hodge, J. V.; and Fraser, R.: Fluorescein Studies of Diabetic Retinopathy. *Brit. Med. J. 1:* 811-814, 28 March 1964.
3. Hodge, J. V.; and Clemmett, R. S.; Impound Method for Fluorescein Angiography of the Retina, *Amer. J. Ophthal. 61:* 1400-4, June 1966.
4. Ellis, P. P. and Smith, D. L.: *Handbook of Ocular Therapeutics and Pharmacology, 2nd Edition* St. Louis. C. V. Mosby 1966.
5. La Piana, F. G. and Penner, R.: Anaphylactoid Reaction to Intravenously Administered Fluorescein. *Arch. Ophthal. 79:* 161-165, February 1968.
6. Reese, A. D.: *Tumors of the Eye, 2nd Ed.* Hoeber Division, Harper and Row Publishers, New York 1963.
7. Norton, E. W. D. and Gutman, Francie: Fluorescein Angiography and Hemangiomas of the Choroid, *Arch. Ophthal. 78:* 121-125, August 1967.
8. Harner, R. E.; Smith, J. L.; Reynolds, D. H.: Fluorescein Fundus Study of Metastatic Breast Carcinoma, *Arch Ophthal. 78:* 300-305, September 1967.
9. Norton, E. W. D. et al: Symposium: Macular Diseases. Diagnosis with Fluorescein in the Study of Macular Disease. *Trans. Amer. Acad. Ophthal. and Otolaryn. 59:* 631-642, 1965.
10. Scott, D. J. et al: Fluorescein Studies of Diabetic Retinopathy. *Brit. Med. J. 1:* 811-814, 1964.
11. Norton, E. W. D.; and Gutman, F.; Diabetic Retinopathy Studied by Fluorescein Angiography. *Trans. Amer. Acad. Ophthal. and Otolaryn. 63:* 109-128, 1965.
12. Smith, J. L.; Gass, D. M. and Justice, J. J.: Fluorescein Fundus Photography of Angioid Streaks. *Brit. J. Ophthal, 48:* 517-521, 1964.
13. David, N. J.; Heyman, A.: Hart, L. M.; Fluorescence Photography of a Retinal Vessel and Optic Discs in Papilledema. *Trans. Amer. Neurol. Asso. 88:* 155-158, 1963.
14. Gass, J. D.; Norton, E. W. D.: Serious Detachment of Retinal Pigment Epithelium. *Trans. Amer. Acad. Ophthal. and Otol. 70:* 990-1015, 1966.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Pre- Intra- and Post-Operative Care Of the Lung Cancer Patient

THOMAS HUTH, M.D.*

Covington, Kentucky

The patient with lung cancer undergoes one of the most hazardous of life's experiences. What can be done to make thoracotomy, and thereby the whole experience, as safe as possible?

THE title emphasizes patient care, rather than care of lung cancers. The "M.D. technician" who merely cuts out cancer, kills patients; while the true surgeon, who supports the patient, palliates many and cures a few. These goals are gained by studying the patient first and his disease secondly; and by applying all possible prophylactic measures to each patient. We cannot predict accurately that the heart will not fail after pneumonectomy, that the emotions will not fall into depression, that cough will not be too feeble, etc. Our predictions are so fallible, and lung surery is so massive, that we cannot foretell which of the physiologic systems may fail. Therefore we must scrutinize the whole man and all his components. We must search out every least measure that may bolster him in his time of jeopardy. Preparations for every eventuality must precede every operation on every patient; only thus can we claim to have done good surgery.

Preparations Before Surgery

In those patients having ill-defined chest lesions that warrant three to four weeks of medical therapy (directed against presumed infection) nutrition can be improved. Weight loss is frequently but not invariably an ominous sign. Anxiety generated by impending surgery can cause weight loss. Serum proteins are routinely studied. If protein level is low, even a few days of high protein diet and albumin infusions will enhance healing of the bronchial stump. Patients with anemia benefit from judiciously administered blood transfusions three to five days before surgery. In particular, one must recognize that the chronically ill have contracted blood volumes, that these smaller blood volumes may be completely hidden by normal hemoglobins, hemotocrits, and RBC determinations. These patients, too, are fit subjects for transfusion.

Smoking is prohibited, eliminating as much tracheobronchial irritation as possible. X-ray studies of heart size and the EKG are always evaluated. Patients with angina or borderline EKG's take the Masters exercise electrocardiographic test. Patients suspected of cardiorespiratory insufficiency have pulmonary function studies to help determine the nature of such problems and to help decide how much lung tissue the patient can safely lose. Bronchoscopy is always done, bronchograms and planigrams frequently, and pulmonary angiograms commonly. The more accurately each pulmonary lesion is delineated, the safer becomes lung resection. The referring physician uses expectorants, xanthines, bronchodilators, mucolytics, the positive pressure respirator and postural drainage to ameliorate bronchitis, asthma and emphysema. The baseline BUN is recorded.

Of all the tests for cardiorespiratory ability to stand surgery, one of the best is the "stairs test". The surgeon who walks with his patients from the basement upstairs to the patients' absolute limit, soon discovers that a one-flight patient is a poor risk, a two-flight patient a fair risk, a three-flight good, and a four-flight excellent. In addition, the heart rate and rhythm are studied. An irregularity that was present before the test and that has disappeared after the patient walks up, is not serious. Conversely, an irregularity that persists, worsens, or first appears after the exercise, is a serious sign. Furthermore, a patient whose pulse rate decreases within three minutes to normal can usually stand any lung resection.

**F.A.C.S., Diplomate American Board of Surgery*

The longer past three minutes required to get the pulse rate back to 76, the greater the risk and the less lung the patient can safely lose.

Arrhythmias are corrected by the referring physician. A patient whose congestive heart failure responds well to digitalis is not denied surgery. But neither is digitalis routinely given, except in those 65 years of age or older. Below this age, even when excision of half the lesser (pulmonary) circulation is planned (i.e., total penumonectomy), digitalis is withheld unless there is evidence of impending cardiac failure.

Electolyte levels are taken as a baseline. They are needed for post-operative evaluation of respiration efficiency, and if digitalis is used, the inotropic effect of potassium must be followed.

Many patients are frightened post-operatively by the intensity of their pain. To prepare them psychologically an instructional interview is given. Herein it is stressed that: 1) chest surgery is painful, but the amount of pain in no way prognosticates either what disease was found or how well the patient is doing; 2) the pain will be minimized by medications; 3) the patient must cough despite the pain.

On the day before surgery blood is cross matched, the bowels are emptied, and the chest is shaved (with soap, because the very useful Phisohex has caused inflammatory changes in razor nicks that have at times necessitated postponement of surgery). Heavy sedation at bedtime insures a night's rest. Siderails are put up to prevent accidents. On the morning of surgery a size 8 F. plastic catheter is introduced through an antecubital vein up into the superior vena cava or into the right atrium. This central venous catheter, attached to a manometer, allows constant monitoring of central venous pressure. The patient comes to surgery well sedated and atropinized but not depressed by excessive narcotics.

Management During Surgery

Aside from preoperative measures, the single greatest safety factor is the choice of anesthetist. Many feel that a physician-anesthesiologist is best; this is usually true. The author has had some anesthetic deaths due to poor administrations by physicians and, conversely, has found some nurse anesthetists surprisingly knowledgeable about open chest anesthesia. Here is no time to respect personages. Here there can be no compromise. Only the best is good enough for the job. A nurse anesthetist who pays attention to her patient, who suctions the respiratory tree often, and who realized that *respiratory movements by the chest wall and diaphragm do not move tracheal air with the chest open,* is fine for the job. A physician-anesthesiologist who has these qualifications is better. Worst of all is the anesthesiologist (or anesthetist) who does not know that (once the chest is opened) the patient's respiratory movements do not move tracheal air, does not realize the job is a three or four hour one of squeezing the bag, eats a sandwich between times, and steps out into the hall for a chat with a kindred soul.

Recently a highly recommended nurse anesthetist, with excellent credentials, and trained at a superior center, horrified the author after two hours of surgery by stating that "she had not suctioned the patient's trachea"!! Massive atelectasis resulted postoperatively necessitating bronchoscopy. After this registered nurse anesthetist was brought to see this patient and his X-ray postopertaively, and had an instructional episode, she seemed to understand. Yet she managed to allow the same complication in a second patient, despite the patient's being in the prone position. Needless to say, she is hopelessly incompetent for open chest surgery. Only the best is good enough.

The author does not advise use of mechanical respirators except temporarily and intermittently (while the anesthesiologist is altering IV fluids, checking blood identifications, etc. Ideally, the anesthesiologist will have an assistant or an R.N. who can manage these chores for him.) The respirators may diminish lung compliance. Also, since these machines do not tire even when flow pressure is set too high, they interfere with venous return, causing hypotension. Furthermore, the educated fingers of the attentive anesthesiologist are constantly following the depth and rate and character of gas exchange. Loss of this physical contact of patient with anesthesiologist when a respirator comes between them is a major step backwards. Too often the anesthesiologist's attention wavers and fails, the patient's condition deteriorates all unnoticed, and a critical situation emerges. There is no substitute for an intelligent, trained, experienced and attentive anesthesiologist or anesthetist.

Surgery is routinely performed with the patient lying on his side. If, despite adequate preoperative treatment, bronchial secretion is present in the upper, operative side that would drain down into the opposite dependent lung, the prone position will circumvent this problem. On occasion a poor risk, elderly, or obese patient is done supine. In the latter position surgery is difficult but not impossible.

After induction of anesthesia and positioning, a manometer is connected to the central venous catheter (described above). Venous pressures are recorded before opening the chest, after opening the chest (with resultant loss of negative pressure), and at selected intervals thereafter. If dissection is bloody or the blood pressure falls for any reason, a normal or low central venous pressure suggests that transfusion will help the situation. If central venous pressure is high, one dare not transfuse but must look to other causes for the patient's poor condition. Usually this will be found to be hypoxemia, either from an inattentive anesthetist who expects the impossible (i.e, expects the patient with open chest to move air in and out of the trachea without manual assistance), or from atelectasis due to bronchial secretions. Very occasionally a high central venous pressure dictates withdrawal of blood from the vascular system.

Lung surgery is vascular surgery; albeit usually *amputative,* at times it must be *reconstructive* vascular surgery. Especially is this true in lobectomy for chronic granulomas or other chromic inflammations. Here all tissue planes are lost, everything is embedded in scar and blunt dissection is impossible. The surgeon is repeatedly "in" and "out" of plumonary vessels. Blood loss is great. Now one must be vigilant lest hemorrhage cause inadvertent clamping of a vessel that is vital to the remaining, unresected lobe. Should this kind of vital vessel be torn, first the finger, and then noncrushing clamps, control the gush, whereupon a calm appraisal of the situation is made. Practically always one sees how to repair the vessel and save the lobe.

Vessels are ligated and then transfixion-ligated. They are tied off as close to the parent vessel as possible. Here, as in any ligated vessel, a blind stump is a nidus for thrombus formation. This was indelibly imprinted upon the author's mind, when, as a resident in pathology, he dissected out the vascular tree in a post-lobectomy autopsy. Every ligated vessel held a thrombus, and every thrombus protruded into the parent vessel as a thrombotic vegetion. Microemboli were present distally in the unresected lobe.

Every effort is made to do true cancer surgery. Granulomas may be stripped off the inside of the rib cage. If a few foci of granulomata are left behind, physiological defenses and antibiotic agents will adequately heal them. Not so with cancer. It must be resected with a wide margin of grossly normal tissue. Sometimes this requires resection of the chest wall itself. Ribs may be shifted to fill in the defects, or prosthetic materials implanted, or the diaphragm may be shifted higher.

Except for Pancoast tumors or superior sulcus cancer, the centrally located carcinomas are a greater and more often insoluble problem than tumors impinging on chest wall. These central malignancies often require total lung resection, often have inadequate margins of normal tissue about them, often are inoperable, and even if resectable, are often followed shortly by the appearance of metastases. Here the preoperative bronchoscopy and bronchograms come into play. They forearm the surgeon with knowledge of the internal pathologic condition of the bronchi. At times referring E.N.T. men are unrealistic in this respect. Having bronchoscoped the patient and having established the diagnosis, they resent the surgeon's re-bronchoscopy. But the visual knowledge attained by the surgeon's personal bronchoscopy, combined with conditions found by inspection of the lung root at the operating table, dictate what course to take.

The author subscribes to this tenet: "Resect for cure if there is any slightest chance of cure, and for palliation if there is any slightest chance of palliation". He has thereby had some surprisingly long term palliations, and a few surprisingly long term "cures". The related question of what to resect, rather than whether to resect, is a complicated one. Recently a well known clinician voiced the opinion that only palliative lung cancer surgery should be done. It is difficult to know what he means. Does he mean that a local resection that removes all gross disease will cure as many as pneumonectomy? Or that mediastinal "clean out" should be reserved for those who have obvious involvement of the

mediastinal nodes? Or that mediastinal "clean out" is useless if there is obvious involvement of medistinal nodes, and instead the primary tumor should be resected for palliation only? Experience has taught the author that such dicta lose their credibility when faced with a concrete problem at the operating table. Usually the necessary course is obvious. Usually chance of cure is either obviously present or obviously absent.

Prior to chest wall closure the bronchial stump is tested by positive pressure inflation of the lung. The stump is tested by water during this maneuver for air leakage. Here a careless anesthetist (who has neither packed the larynx tightly around the endotracheal tube with soft bandage nor used an inflatable endotracheal tube, or has unwittingly jammed the endotracheal tube into the opposite main bronchus) will give a false impression of a tight bronchial stump. In the former instances the gases will leak out through the larynx, and in the latter the positive pressure will be exerted in the wrong lung. In both instances a false sense of security will appear. The surgeon must know what the anesthetist is doing at all times. By meticulous care to these points and despite several "scares and alarms", the author has had only one prolonged air leak (which closed without reoperation). He has had no stump breakdowns.

The chest cavity and the subscapular space are inspected for bleeders and sponges before closure of the chest. Chest tubes to water seal bottles assure prompt lung re-expansion of any remaining lung.

Post Operative Care

Oxygen is usually needed because pain limits depth of respirations. The Fowler's or semi-Fowler's position helps breathing; even if the blood pressure is low, semi-Fowler's position is mandatory. The chest tubes are milked repeatedly for several hours post-operatively, gradually decreasing thereafter. This is done to dislodge clots in the tubes. Urine output and central venous pressure are watched closely. They readily guide the rate and quantity of intravenous fluid. Coughing is stimulated if necessary by nasotracheal aspirations with rubber catheters. Narcotics are not given upon recovery from anesthesia until the B.P. comes up to the normal preoperative pressure. Intermittent positive pressure respiration is begun if secretions are voluminous or if respiratory motions are shallow, first being certain that chest tubes are patent. Positive pressure used in the post-resectional period can cause tension pneumothorax and death if the chest tubes are not patent. On the very day of surgery the patient is required to use the shoulder so as to prevent prolonged shoulder weakness. Air leak from alveolar surfaces stops and allows removal of tubes by the fourth or fifth day. Although occasional patients have a minor collection of intrapleural fluid, with or without loculation, these are generally best let alone. The inexperienced surgeon or radiologist is apt to be overly anxious about and overly zealous in treating postoperative roentgenograms. Frightening films result from pleural edema, tube tracts, muscle bulging through the intercostal wound into the chest, fluid under the scapula and suture lines in remaining lung parenchyma. The clinical progress is essential in interpreting (and more important than) the X-rays. Passage of a month or two clears up 99 percent of the surgical residuals that are detectible on X-ray films. Having made an all-out surgical effort, and having used all proper care for details of technique, the surgeon is usually well advised to let nature overcome minor deviations from normal. Bronchoscopies, thoracenteses, tube thoracotomies and intrapleural injections can be not only tiring, but even dangerous to a poor risk patient. Complications requiring intervention will usually be obvious from hypotension, tachycardia, tachypnea, cyanosis, rhonchi, tracheal shift, confusion, massive air leak through the chest tubes, or oliguria. Fortunately, these seldom occur, and their causes are commonly readily apparent and correctable.

On the average, major thoracotomy cases return home about the tenth post-operative day. They are re-evaluated at three and six weeks, and then revert completely to the referring physician. They generally return to sedentary work two months after, or to physical labor three months after, their surgery.

Case Report of a Paint-Thinner Sniffer (Enamel Reducer)

PANG L. MAN, M.D.*

Lexington, Kentucky

Paint-thinner reducer (enamel reducer), easily obtained in an auto body shop, induces a psychosis. An EEG taken before, during and after a "trip" was normal. Sniffing may lift the defense mechanism —repression. Efforts have been made to compare glue-sniffing with paint-thinner sniffing.

THERE have been several reports in the literature[1,2] concerning young children and adolescents who were glue-sniffers, and who became temporarily psychotic as a result of the experience. However, with the exception of Nylander[3] of Sweden, nothing has been reported about paint-thinner addiction in children. Teenagers and college students who frequently use psychodelic drugs, such as LSD, or narcotics, such as marijuana, cocaine, heroin, etc., usually are searching for something "new"; they desire exeitement and "kicks."

There now appears to be an increasing trend for young people to sniff paint-thinner—an inexpensive preparation which is easy to obtain from the auto body shop or paint dealer, and which has psychodelic effects similar to those of other preparations used for this purpose. By sniffing paint-thinner the individual may have a "trip", the usual effect he is seeking. Some evidence indicates that the frequency of paint-thinner sniffing is greater in California than in any other state.

The patient whose experiences are described in the present report was a 22-year-old, single, white male, admitted to Eastern State Hospital, a state psychiatric hospital. Physically, the patient was handsome, well-nourished, and well-developed for his chronological age. He was cooperative and verbalized well—speaking relevantly and coherently. His affect was appropriate; he denied morbid ideation, and there was no evidence of psychosis. Results from routine laboratory examinations fell within normal limits. Psychological testing provided evidence of a character disorder associated with antisocial behavior, and the psychiatric diagnosis was that of a sociopathic personality disorder.

The patient had been sniffing "Ditzler-101" for about 15 months, on the average of once or twice a week. He reported that four persons of his acquaintance had sniffed a total of four gallons of Ditzler-101 in a seven-day period. Ditzler-101 is a highly volatile solvent, commonly used as an enamel reducer. It contains toluene and petroleum distillate. The patient had a history of using marijuana, cocaine, opium and heroin in addition to paint-thinner. He had been arrested for disorderly conduct at the time of the present study, and in the past had been in the local jail and in prison for other charges.

The following narrative presents a descriptive account by the patient of his experiences while using Ditzler-101. In addition, an electroencephalographic recording was made before, during, and after the patient had sniffed the paint-thinner.

"My first experience with Ditzler-101 was in June, 1967. I was smoking marijuana, and someone suggested that we sniff Ditzler. So we all started sniffing. The effects were just a 'high' feeling which seemed to be a tingling 'high' that lasted about three or four hours.

"The first time I took a 'trip' or had hallucinations was about a month later. I was with five other guys and we were all sniffing. We decided to have a contest and see who could take the most 'hits' or deep breaths on the bag. We had a plastic bread bag with a rag soaked in Ditzler. I was the first one to try it and I started taking deep breaths. I can remember

*Clinical director, intensive treatment services, Eastern State Hospital, Lexington; clinical instructor, department of psychiatry, University of Louisville School of Medicine, Louisville

taking 20 hits and then I started having my trip.

"I imagined I was sitting in front of a huge mirror and I had on a military aeademy uniform, and there was an offieer with a woman eoming down a line of other men dressed the same. Then the man touehed me on the shoulder with the sword and waited a minute. Then the woman said, 'That's just like one of those Navy rentals, they never know what to do.'

"Then I eame to and realized where I was. I wanted to see if the same thing would happen, so I started to hit the bag again. This time I thought I was caught in a rose trellis at the bottom of a girls' dormitory at a eollege. After struggling for a minute, I eame to again.

"That was all the trips I took that night. The next night I tried it again, and this time I thought I was at Coney Island riding the Wildcat.

"Some of the other trips I can remember include a trip where I thought that I was Hereules and I was in an arena and about to fight a gladiator. I eould see the gladiator and I eould see the people all around.

"At another time I saw a ghost of a woman, a prostitute, and she was there to do anything I asked, only I eould not toueh her beeause she was a ghost.

"One time I talked to an old woman and she told me how I eould use this maehine to travel in time and that I was from the future, and that I had been lost in the past and if I got in this machine I would travel baek to where I belonged.

"Right after Kennedy was shot, I thought I was being trained to assassinate people, and all of a sudden I realized it and I was trying to eseape from the plaee they had me a prisoner.

"Onee I was sitting by a small woods and I saw a tree start walking toward me. I asked the tree why it was walking and it told me it eould walk as long as I was sniffing the thinner. We talked for awhile, and then it walked baek where it was and I eame to.

"Another time I was by a lake and I thought I heard my father's voice, so I started talking to him. We talked for awhile, and then he went away and I eame to.

"Then there was the time myself and three other guys were sniffing, and I felt blood on my faee. I was lying on the ground and the side of my head had been blown off. The other guys were standing over me and I heard an ambulanee eoming.

"Onee I was watehing 'I Spy' on television and I saw a sign that said, 'When you see the light take pietures', so when I saw the light in the eorner of the sereen I started taking pietures and I thought it was pietures to use in my spy work.

"Onee I talked to a man from outer spaee and he told me all about his spaee ship, and then I eame to.

"The more times I went on a trip the longer the trip lasted. At first the trips were just for a minute or a minute and a half, but after awhile they lasted for up to two to three hours, and I eould not always remember the trip."

An analysis of the symptoms, based on the patient's verbal reports and on behavioral observation of the patient suggests that symptoms elieited by paint-thinner sniffing are similar to those elieited by glue-sniffing.[2] These are compared in Table I.

There have been reports that glue sniffing affeets the eleetroeneephalogram, with spikes and slow delta waves in six out of 10 eases.[1] In some experiments on human subjeets[5] using laequer-thinner, no abnormal eleetroeneephalograms were produced. To determine the effeets of using Ditzler-101 on the EEG, reeordings were made of the patient being studied before and after the patient had sniffed the paint-thinner and indueed the "trip", as well as a reeording during the aetual experienee of the trip. The EEG reeordings before, during, and after the "trip" were essentially normal, with no dysrhythmia.

Discussion

As a matter of interest, data from the present ease study indicate that the sequence of experienees indueed by the paint-thinner sniffing are as follows: a feeling of being "high", then the aetual "trip" itself, and finally a reversion to the "high" for a period of time.

Some authors have maintained that adolescents who resort to "sniffing" typically are from a lower soeioeeonomic elass, often vietims of culturally-deprived families or from broken homes. Rejeetion of the child by the parent is said to be a eommon baekground theme. This is consistent with the family situation of the

TABLE I

Comparison of Symptoms of Glue-Sniffing and Paint-Thinner-Sniffing

Symptoms Associated with Glue Sniffing	Symptoms Associated with Paint-Thinner Sniffing
1. Nausea, vomiting	Same
2. Loss of appetite	Less appetite, but increased thirst
3. Excessive salivation	Occurs, but later in time
4. Drowsiness	Same
5. Weakness	Same
6. Light-headedness	Same: also feeling of "puffiness"
7. Sense of physical lightness	Not present
8. Sense of spinning, moving, floating, a magnetic pull	Same
9. Distorted space perception	Same
10. Altered shapes and colors	Altered shapes only
11. Micropsia	Same
12. Amnesia	None
13. Hyperacusis	Same
14. Visual, auditory, tactile hallucinations	Same
15. Dream-like state	Same
16. Euphoria	Same
17. Fear	Same
18. Guilt	Same
19. Loneliness	Same
20. Grandiosity	Same
21. Temporary misinterpretation	Same
22. Loss of sexual desire (None)	Yes

patient in the present study; the patient's father was a truck driver who drank heavily each evening; fights and quarrels among family members were very common, and eventually the patient's father and mother separated. During the trip observed in the present study the patient screamed repeatedly, "Where is my mother? Does she call?" In a subsequent interview in which the patient described the trip, he said that he had thought that he was a lost child, and that he was longing for love and for help.

One may also speculate concerning the psychodynamics of glue-sniffing or paint-thinner sniffing. It is a tenable assumption that in the course of sniffing, the fundamental defense mechanism of repression is lifted; the patient experiences either directly or in symbolic form fantasies that plumb the depths of his problems, and at the same time wish-fulfilling fantasies that will permit him to escape or deny his problems. The patient's account of experiences related to his various "trips" may then be related to this interpretation; for example, the focus of several of the experiences (e.g., the Naval Academy, the fight with the gladiator, the "spy" work) was on demonstrating strength, power, or fortitude; the patient may have been indicating that he wanted to be a strong and important man so that he could be reunited with his father and receive the love and help that he needs but cannot admit at a conscious level.

The recurring themes of the trips, however, are those of depression and failure. In the trips the patient sees himself as ineffective and sexually inadequate, as trapped, being held prisoner, and as being helplessly wounded. Symbolically, during the trip, the patient considers escape from his problems by the use of a time-machine or a trip to outer space—as in real life he attempts to escape from his problems by sniffing the paint-thinner. It is thus suggested that the patient's paint-thinner sniffing, like his other forms of antisocial behavior, have represented a form of rebellion against his parents—and a denial of his love for and need of the parents which becomes manifest in his psychodelic experiences.

Summary

A 22-year-old, single, white male had a history of paint-thinner sniffing for 15 months. He presents more or less the same clinical picture as the glue sniffer does. Electroencephalograms were taken before and after the paint sniffing during which the patient had a trip. They were found to be normal. The possibility that paint-thinner sniffing lifts the defense mechanism, repression, is discussed. The pa-

(Continued on page 230)

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1969 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 23, 24, 25**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

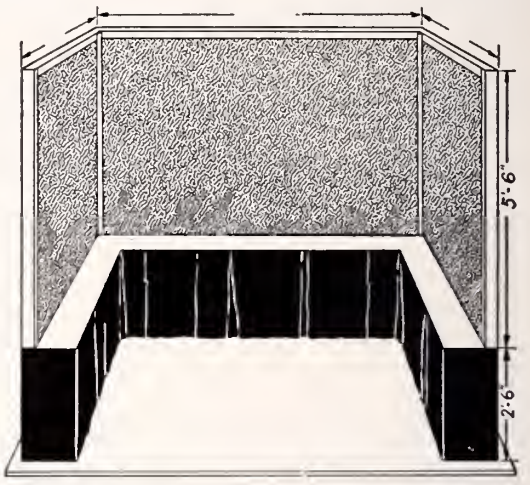
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1969

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)

 Institution (if desired):

 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)

 Charts and Posters.... Photographs.... Drawings.... X-rays

 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

 Amount of total wall space needed?

 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided to you in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



SPECIAL ARTICLES



Adult Diabetes Mellitus
A Critique of the Diagnosis†

JAMES ROBERT HENDON, M.D., AND DAVID WHITE, M.D.
Louisville, Kentucky

This paper presents original ideas about hyperglycemia and diabetes mellitus which should be of interest to our readers—The Editors.

THIS discussion will arbitrarily exclude from consideration the metabolic disorder known as 'juvenile' or 'brittle' or 'insulin-dependent' diabetes mellitus. It will deal only with the abnormal state which usually has its onset in the middle years of life and is characterized by hyperglycemia and the infrequent occurrence of ketosis. This clinical state presently goes by the name 'stable' or 'insulin-resistant' or 'adult-onset' diabetes mellitus.

About 400 years before Christ, Plato said, "If you would speak with me, first define your terms." In working in an endocrine clinic populated largely by middle-aged and elderly, overweight, hyperglycemic individuals who had been referred for treatment of 'diabetes mellitus', it occurred to us that we could not, to our satisfaction, categorize all of these patients as actually having diabetes mellitus. Unless we were willing to accept the proposition that all hyperglycemia-unresponsiveness is diabetes mellitus, we were sadly lacking a definition.

In such a situation, one turns to authoritative texts for clarification. One of these[1] defines the condition as a chronic disease, genetically determined and directly attributable to a deficiency in insulin action. Further definitive comment incriminates the pancreas, the adenohypophysis, the adrenal cortex, or the thyroid. Another source[2] discusses excellently and in depth the characteristics of diabetes mellitus, but does not precisely define it. Still another[3] speaks of a chronic disorder of carbohydrate metabolism resulting from relative or absolute insulin deficiency.

Questionnaires requesting definition were sent to 200 members of the Endocrine Society and the American Diabetes Association as representing that sector of medical thought most likely to furnish the exclusively identifying characteristics of diabetes mellitus. There were 44 replies. The majority of these ran somewhat as follows: "Adult-onset diabetes is that form of diabetes which . . .". "A mild or moderate intolerance becoming manifest in an adult." "A disease state, most likely hereditary, in which the patho-physiology is quite widespread, not very well understood, can and does affect every system in the body. It is usually best treated . . ." And so on.

None of these sources, we felt, clearly delineated an entity which might be called 'diabetes mellitus' — unless we were willing to accept all hyperglycemia-unresponsiveness as 'diabetes mellitus'. Unfortunately, it is not merely a matter of semantics that is involved here. One might say, certainly, that all hyperglycemia-unresponsiveness is the result of insufficient insulin activity. At least, all hyperglycemia can be reduced by injection of adequate amounts of insulin. This line of reasoning is unwise to follow, however. We are confronted by several considerations. The *usual* criteria for the diagnosis of diabetes mellitus are consistently abnormal glucose tolerance tests and/or postprandial hyperglycemia. It is commonly accepted that, by appropriate measures, the elevation of the blood sugar can be controlled but not 'cured'. (Whether such 'control' affects the

†*Presented at the joint meeting of the Kentucky Chapter, American College of Physicians and the Kentucky Diabetes Association, September 26, 1968*

course of the disorder is less clear.) At any rate, when carbohydrate intolerance is so encountered, a diagnostic dead-end is reached, followed inexorably by the therapeutic sequelae of diet and insulin, or other hypoglycemia agents.

Yet it is well known that pheochromocytoma is associated with hyperglycemia, and that removal of the offending tissue is followed by return of the blood sugar to normal. Adrenal cortical tumors produce hyperglycemia which is reversed after appropriate surgery. We have seen one patient in the endocrine clinic of the Louisville General Hospital who had been treated for several years for diabetes mellitus, and whose hyperglycemia decreased when undiscovered hyperthyroidism was appropriately combatted. Growth hormone has hyperglycemic effects as attested by the fact that some 50 percent of acromegalics have carbohydrate intolerance.[4] Moreover, in such patients, the hyperglycemia decreases as the hyperpituitarism is successfully treated, or becomes quiescent. Figure 1 lists some of the causes of hyperglycemia or glycosuria other than 'diabetes mellitus'.

Since the liver is the main carbohydrate storehouse for the body, it is not surprising that disorders of the liver are frequently associated with abnormalities of blood sugar. Hemochromatosis is the most spectacular of these. Keen[5] reported a bizarre instance of fluctuating hyper- and hypo-glycemia in a man with multiple hepatic tumors. Figure 2 shows

REASONS FOR HYPERGLYCEMIA AND/OR GLYCOSURIA

1. ACROMEGALY
2. CUSHING'S DISEASE
3. HYPERADRENALCORTICISM
4. HEPATOCELLULAR DISEASE
5. HEMOCHROMATOSIS
6. PHEOCHROMOCYTOMA
7. HYPERTHYROIDISM
8. ACTH, GH, GLUCAGON, PROLACTIN
9. NEPHROSIS
10. ALIMENTARY GLYCOSURIA
11. INTRACRANIAL INJURY
12. SHOCK
13. ASPHYXIA
14. PAIN
15. ANESTHESIA
16. EMOTIONAL DISTURBANCES
17. SMOKING
18. PREGNANCY
19. RENAL GLYCOSURIA
20. THIAZIDE DIURETICS
21. HYDRALAZINE
22. GUANETHIDINE
23. DIAZOXIDE
24. LSD

FIGURE 1 (from Keen[5])

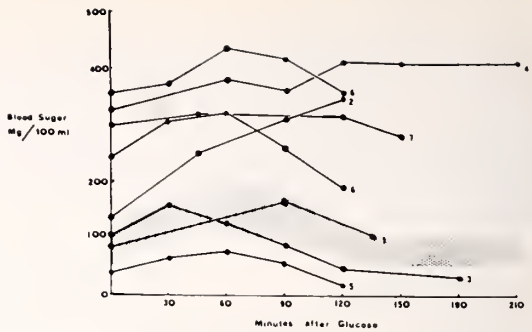


FIGURE 2. Multiple glucose tolerance curves on patient with hepatic tumors. (From Keen, H., Guy's Hospital Reports)

a series of glucose tolerance tests performed on this patient. Various hepatotoxic drugs can produce hyperglycemia[6], as may sulfonamides[7], diazoxide[8,9], the chlorothiazides[10] and others[11,12,13]. Blood sugar returns to normal on discontinuance of the drug. The effect of the contraceptive hormonal preparations on blood sugar is not yet clear[14].

Even in the absence of a satisfactory definition, it would seem quite inexpedient to regard all of the foregoing states as 'diabetes mellitus'.

If all hyperglycemia is not diabetes mellitus, then is all diabetes mellitus hyperglycemia? Because of our difficulties with definition, it is again hard to say. There are increasing numbers of reports, however,[15,16,17,18] of the presence of lesions considered to be pathognomonic of diabetes mellitus in individuals with no demonstrable carbohydrate abnormality. Thus, nodular glomerulosclerosis[19,20], typical retinal microaneurysms[21,22], thickening of muscle capillary basement membrane[23] all seem to occur in the absence of hyperglycemia-unresponsiveness. That many such individuals eventually develop hyperglycemia is not completely germane. One cannot escape the conviction that some more basic pathological process is the primary offender.

It seems to be true, on the other hand, that long-standing, clinical and experimentally produced hyperglycemia will lead to vascular changes usually considered characteristic of diabetes mellitus[24,25,26,27,28]. When we consider, however, that such changes never occur early in the experimental animals, and that, in humans, the angiopathy may actually precede the hyperglycemia, these findings lose some of their import.

It does appear, then, that our preoccupation with blood sugar levels in the past may have

been misplaced. Again, were this a matter merely of semantics, its presentation to this group would not be justified. This is not the case, however. Medical literature is replete with studies of large series of cases of so-called 'adult-onset diabetes mellitus'. Concepts of pathophysiology and of therapy are formulated on the bases of such studies. "Which patient has the diabetes?"

Regretfully, we can offer no clear-cut and completely delineating definition of diabetes mellitus. We urge that students of the disorder everywhere turn all their energies toward discovering a precise and exclusive real definition. Such efforts, when fruitful, will bring order out of what is now confusion, and must certainly provide basis for progress in our management of the disorder.

Where shall the search be centered? There is little or no disagreement that the disorder we are contemplating is an angiopathic one. May a genetic defect, or one produced by sustained carbohydrate intolerance implicate enzymatic mechanisms resulting in vascular changes *and* hyperglycemia[29]? Insulin and glucose suppress the release of non-esterified fatty acids (NEFA) in normal subjects. In certain hyperglycemic individuals, however, there is an increase of NEFA despite the hyperglycemia[30]. In such subjects, the hypoglycemic effect of exogenous insulin may be delayed until the level of NEFA has been reduced. The lipogenetic effect of insulin, on the other hand, is not inhibited, thus allowing continued build-up of adipose tissue[31,32,33,34].

Many tangential considerations arise from these and other observations. Until they are resolved, however, until diabetes mellitus is really defined, we make the radical, but reasonable, proposal that the term 'adult-onset diabetes mellitus' and its equivalents be dropped from medical nomenclature, and that individuals with hyperglycemia-unresponsiveness receive the more realistic diagnosis of 'Hyperglycemia—Cause Undetermined'. Use of this term will require that we define what blood sugar levels really constitute hyperglycemia at different ages of adult life. It should suggest consideration of the question of whether a mild hyperglycemia *per se* requires any treatment. Finally, such a diagnosis will serve as a constant challenge to us to determine the cause, and in some cases we actually will.

Bibliography

1. Duncan, G. G., *Diseases of Metabolism,* 920 et seq., W. B Saunders Co., Philadelphia, 1964.
2. Williams, R. H., *Textbook of Endocrinology,* 613 et seq., W. B. Saunders Co., Philadelphia, 1968.
3. Forsham, P. H. et al., *Principles of Internal Medicine,* 635, McGraw-Hill, New York, 1962.
4. Williams, R. H., *Textbook of Endocrinology,* 790, W. B. Saunders Co., Philadelphia, 1968.
5. Keen, H., "Fluctuating Hyper- and Hypoglycemia Associated with Multiple Hepatic Tumors", *Guy's Hospital Reports III* 200, 1962.
6. Thomson, J. S. et al., "Liver Damage and Impaired Glucose Tolerance After Paracetamol Overdosage", *British Medical Journal* 5512:506, 1966.
7. Muting, D. et al., "Cirrhosis of the Liver and Diabetes Mellitus", *Germ. Med. Monthly XI* 385, 1966.
8. Tabachnick, I. I. A. et al., "The Effect of a Benzothiadiazine, Diazoxide, on Carbohydrate Metabolism," *Diabetes 13,* 408, 1964.
9. Wolff, F. W. and Parmley, W. W., "Further Observations Concerning the Hyperglycemic Activity of Benzothiadiazine", *Diabetes 13,* 115, 1964.
10. Paschkis, K. E. et al., *Clinical Endocrinology,* 806, Harper and Row, Hoeber Med. Div., New York, 1967.
11. Goldman, J. A. and Schechter, A. "Effect of Cigarette Smoking on Glucose Tolerance in Pregnant Women", *Israel J. Med. Sc. 3,* 501, 1967.
12. Okun, R. et al., "The Hyperglycemic Effect of Hypotensive Drugs" *J. Chron. Dis. 17,* 31, 1964.
13. Elder, J. T., "Antagonism of Lysergic Acid Diethylamide (LSD) - induced Hyperglycemia", *Int. J. Neuropharmacol. 3,* 295, 1964.
14. Spellacy, W. N. and Carlson, K. L., "Plasma Insulin and Blood Glucose Levels in Patients Taking Oral Contraceptives", *Am. J. Obs. & Gyn.* 95, 474, 1966.
15. Ditschuneit, H., "Prediabetes", *Germ. Med. Monthly XI,* 65, 1966.
16. Ellengerg, M., "Clinical Concept of Prediabetes" N. Y. *St. J. Med. 64,* 2885, 1964.
17. Ellenberg, M., "Diabetes in the Older Age Group", *Geriatrics 19,* 47, 1964.
18. Fineberg, S. K., "Application of Newer Concepts of Diabetes", *J. Am. Ger. Soc. XIV,* 463, 1966.
19. Levine, R., "History of Etiology of Diabetes Mellitus", *Arch. Path. 78,* 405, 1964.
20. Harrington, A.R. et al., "Nodular Glomerulosclerosis Suspected during Life in a Patient without Demonstrable Diabetes Mellitus," *N.E.J. Med. 275*:206, 1966.
21. Linner, E. et al., "Retinal and Renal Lesions of Diabetic Type without Obvious Disturbances in Glucose Metabolism in a Patient with Family History of Diabetes," *Am. Jour. Med* 39:298, 1965.
22. Lavyel, A. and Wolfsohn, H., "Microaneurysms of the Conjunctiva as Evidence of Latent Diabetes or Prediabetes," *Bull. Anat.* 7:537, 1965.
23. Siperstein, M. et al., "Muscle Capillary Basement Membrane Width in Normal, Diabetic, and Prediabetic Patients," *Trans. Assn. Amer. Phy. lxvlx*:330, 1966.
24. Becker, D. and Miller, M., "Presence of Diabetic Glomerulosclerosis in Patients with Hemochromatosis," *N.E.J. Med. 263*:367, 1960.
25. Burton, T. T. et al., "Diabetic Retinopathy Following Total Pancreatectomy," *Proc. Staff Meet. Mayo Clin. 32*:735, 1957.
26. Duncan, J. P. et al., "Diabetic Retinopathy and Nephropathy in Pancreatic Diabetes," *Lancet 1*:822, 1958.
27. Heath, H. et al., "Retinal Angiopathy in the Iminodipropionitrile Treated Alloxan-diabetic Rat," *Br. J. Exp. Path.* 47:116, 1966.
28. Sprague, R. G., "Diabetes Mellitus Associated with Chronic Relapsing Pancreatitis", *Proc. Staff Meet. Mayo Clinic 22,* 553, 1947.
29. Erlanger, S. R., "Common Enzyme Deficiencies May Cause Atherosclerosis and Diabetes Mellitus", *Enzymologea 28,* 139, 1965.
30. Jakobson, T., "Serum Lipids and Glucose Tolerance in Subjects with Family History of Diabetes Mellitus", *Act. Med. Scan. 178,* 181, 1965.
31. Gordon, E. S., "Lipid Metabolism, Diabetes Mellitus, and Obesity", *Adv. in Int. Med. 12,* 66, 1964.
32. Sullivan, J. F. et al., "Serum Lipid Abnormalities in Diabetes Mellitus", *Ther. Res.* 7, 28, 1965.
33. Randle, P. J. et al., "The Glucose-Fatty Acid Cycles in Obesity and Maturity Onset Diabetes", *Ann. N. Y. Acad, Sc. 131,* 324, 1965.
34. Vallance-Owen, J., "Synalbumen Antagonism in Obesity and Maturity Onset Diabetes Mellitus", *Ann. N. Y. Acad. Sc. 131,* 315, 1965.

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

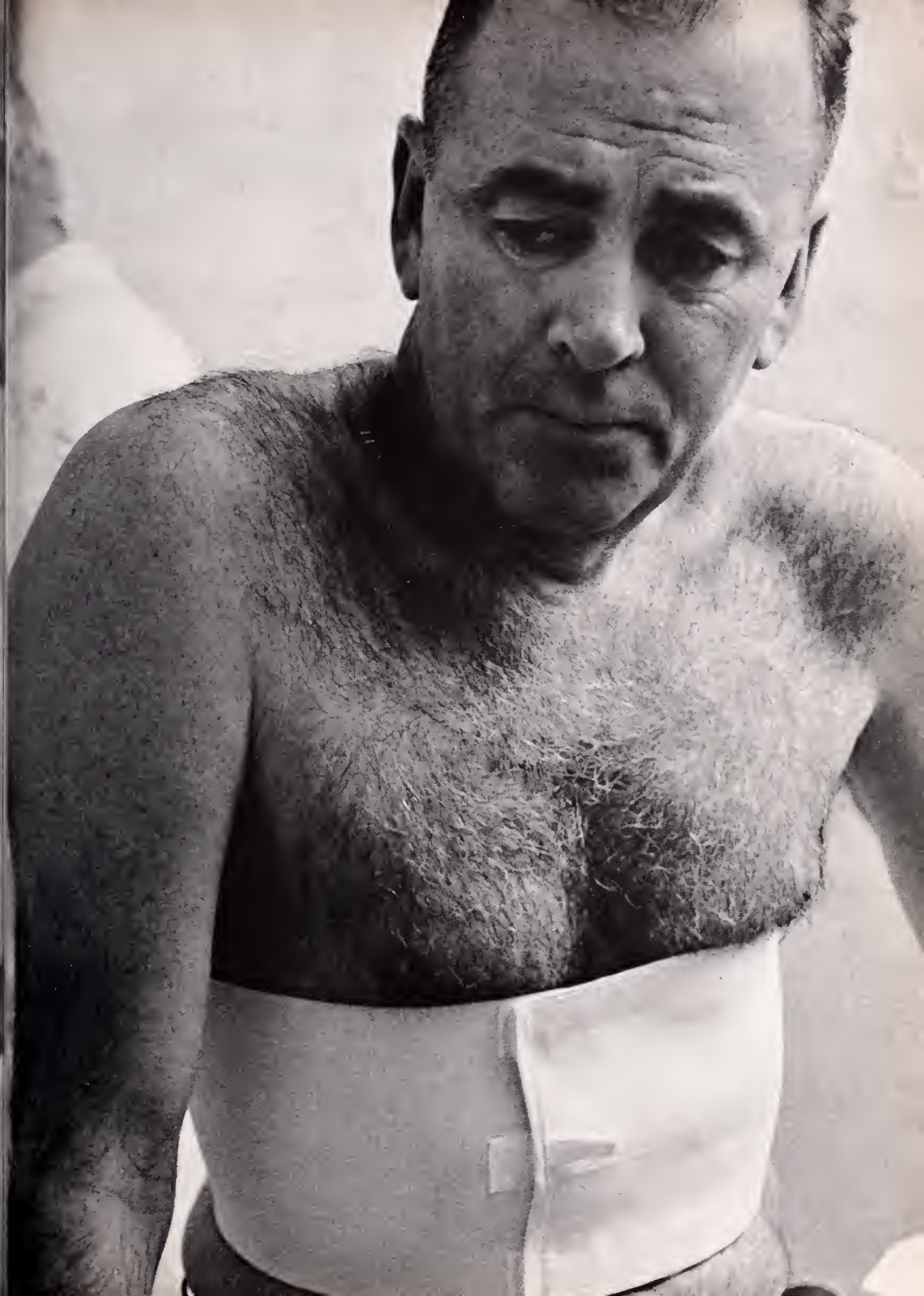
Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





EDITORIALS

Health Careers in Kentucky

THE Kentucky Medical Association and its Auxiliary are now officially members of the Advisory Council of the Health Careers in Kentucky.

Upon recommendation of the KMA Health Careers Committee the Board of Trustees voted to appropriate in support of its membership on the Council a sum equivalent to $1 per member per year. In addition, because of the Auxiliary's continuous interest in and contribution to programs in health career recruitment, the Board recommended to underwrite the Auxiliary's membership on the Council. This amounts to $50 per year.

Health Careers in Kentucky was organized and developed by the Kentucky Hospital Association at the request of the Kentucky Allied Medical Council, and it is intended to represent the cooperative efforts of all interested health organizations and agencies within the state.

Its major purpose is to improve the recruitment of candidates for careers in health within the state and promises to become the focal point for such activities in the very near future.

The Health Careers Committee feels HCIK merits the full endorsement and support of the Kentucky Medical Association and calls upon all of its members to cooperate actively with this organization.

JOSEPH HAMBURG, M.D., CHAIRMAN
KMA HEALTH CAREERS COMMITTEE

Fair Representation

AT A recent meeting of the Jefferson County Medical Society, William Moses, M.D., indicated that the number of Negroes graduating from dental and medical schools in the United States is declining. Coming from so highly respected a physician as he, this rather surprising conclusion seemed to merit further study. Consequently, I inquired of the Division of Medical Education of the AMA and of the deans of our two medical schools to learn that Doctor Moses' statement is correct at least with respect to our state.

For the AMA, Hayden C. Nicholson, M.D., replied, "The AMA and the National Medical Association through the Liaison Committee are undertaking to acquire current statistics on the number of Negro medical students and graduates. My impression is that during the last 10 years there has been a slight increase in the number of Negroes enrolled in and graduated from American Medical Schools but that, since there has been an over-all increase in the number of students and graduates, the percentage of Negroes has increased little, if at all, and actually may have decreased." Charles E. Wagner, M.D., associate dean of the U. of L. School of Medicine, stated that there have been three Negro graduates during the last 10 years and none during the past seven years. He adds, "The number of Negro applicants has always been low. Recently we have made a special attempt to attract qualified Negro students to apply to the medical school. Because of

this program I expect the number of Negro applicants to increase."

William S. Jordan, Jr., M.D., dean of medicine at U. K. wrote, "Our Admissions Committee has turned down only two of all the students who applied to us who were known to be black, and one of them was from out of state. Since the number of black applicants has been small so has the number of Negro graduates. It would appear that this number has neither increased nor decreased. We have concluded that it cannot be increased until we and others increase our efforts at the high school and college level to recruit more blacks for the health professions." In the five graduating classes at Lexington there have been five Negroes; there are three now in the sophomore and junior classes.

It may be appropriate to speculate as to the reasons for this disparity. Negroes comprise 15 percent or more of Kentucky's population and about the same percentage nationally, and they make up less than one percent of our medical graduates in this state. First of all we do not believe it is a fault in any measure of the admissions committee's policy of selection in either of our schools. We believe, as both deans have stated, that it is because qualified applicants have not presented themselves. These committees use every practical device at their command to select from candidates those who show by scholarship, motivation and otherwise those qualities which will most likely assure that they will pursue a full course of medical training and will not become dropouts, thereby depriving another worthy person of a chance. And even at that they constantly have up to a 10 percent error. No one can predict from a group of applicants who will become a good physician or dentist and bring honor to the profession; to expect that he will continue and obtain a degree is uncertain enough.

Many more Negroes are seeking a higher education now than ever before. It seems that their goal is more toward physical education, teaching, or the ministry than toward scientific or even business careers. This is perhaps the principal reason for so few qualified applicants to medical or dental schools.

The question arises as to whether many Negro students with good scholarship and motivation can afford financially to enter upon the long and admittedly expensive period of training required in medicine. A large percentage of students now in training are without adequate financial support. There are, however, fairly ample provisions in all medical schools for free scholarships or loans. These resources are equally available to all and a promising Negro candidate will, in all probability, be able to obtain financial help more readily and perhaps in larger amounts than almost any others.

Motivation for one reason or another would seem to be the most vital element in assuring a Negro candidate acceptance to almost any of our medical schools. An intelligent effort at recruitment therefore is the most important step that we as physicians and dentists can employ in an effort to improve this situation which most certainly must concern us all. There is healthy and stimulating competition for every available opening in the freshman medical and dental classes every year. Fairness in the selection of applicants has always been hopefully expected and our admission committees continue to do a clean and honest job of it—but we should try by every honorable means to give Negroes a better representation in our professions.

SAM A. OVERSTREET, M.D.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

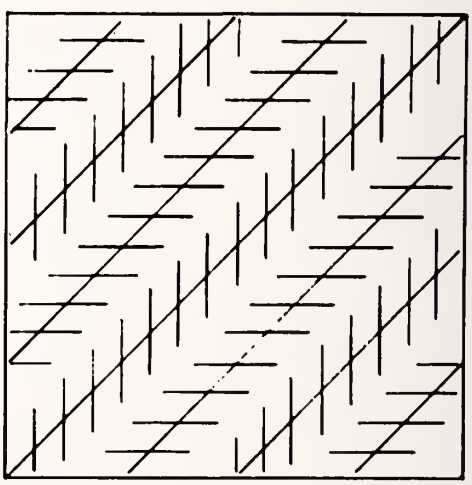
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.







Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000. Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B) R3-46-560-B

Under license from
Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets



They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a natural curb on appetite and frequently promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN depressants. As with all CNS-acting drugs, cau tion patients against hazardous occupations re quiring complete mental alertness (*e.g.*, operatir machinery, driving). Though physical and ps; chological dependence have rarely been reporte on recommended doses, use caution in ac ministering Librium (chlordiazepoxide hydr chloride) to known addiction-prone individua or those who might increase dosage; withdraw symptoms (including convulsions), followin discontinuation of the drug and similar to thos seen with barbiturates, have been reported. Us of any drug in pregnancy, lactation, or in wome of childbearing age requires that its potenti benefits be weighed against its possible hazard As with all anticholinergic drugs, an inhibitin effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate limit dosage to smallest effective amount to pre clude development of ataxia, oversedation c confusion (not more than two capsules per da initially; increase gradually as needed and tole

or here.



ed). Though generally not recommended, if mbination therapy with other psychotropics ems indicated, carefully consider individual armacologic effects, particularly in use of po- ntiating drugs such as MAO inhibitors and enothiazines. Observe usual precautions in esence of impaired renal or hepatic function. radoxical reactions (*e.g.*, excitement, stimula- on and acute rage) have been reported in psy- iatric patients. Employ usual precautions in eatment of anxiety states with evidence of im- nding depression; suicidal tendencies may be esent and protective measures necessary. Vari- le effects on blood coagulation have been ported very rarely in patients receiving the ug and oral anticoagulants; causal relation- ip has not been established clinically.

ADVERSE REACTIONS: No side effects or anifestations not seen with either compound one have been reported with Librax. When lordiazepoxide hydrochloride is used alone, owsiness, ataxia and confusion may occur, pecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Public Enema No.1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-

ORGANIZATION SECTION

KMA Finalizes Plans For 1969 Interim Meeting

A high attendance of physicians is expected at the 1969 Interim Meeting of the Kentucky Medical Association March 26 and 27 at the Continental Inn, Lexington, according to Henry B. Asman, M.D., KMA president and program chairman.

Authoritative guest speakers have consented to participate in the two-day program which will begin with a dinner Wednesday highlighted by Governor Louie B. Nunn's keynote address on health matters in Kentucky. The meeting will close with a luncheon session Thursday featuring a talk on "Blue Shield's Partnership with Medicine," by George Dunlop, M.D., Boston, Mass., president of Massachusetts Medical Service.

Four speakers will present a panel discussion of Comprehensive Health Planning Thursday morning, moderated by George F. Brockman, M.D., Greenville, KMA past president. The participants, all active in health planning roles, include Frank Groschelle and Strawn Taylor, Frankfort, Senator Clyde Middleton, Covington, and Frederick A. Stine, M.D., Ft. Thomas.

Other speakers participating on the morning program are Donald E. Wood, M.D., Indianapolis, Ind., who will discuss "Health Manpower—Mostly!", and Norman E. Farber, New York, N.Y., whose topic is "Health Careers Program of the National Health Council." Mr. Farber is the director of the Council's Health Careers Program.

In conjunction with the Interim Meeting, the Eighth KMA Orientation Program for new members will be presented and the KMA Woman's Auxiliary will meet. Doctor Asman urges all Kentucky physicians to attend this exciting, informative session.

Six KMA Trustee Districts Plan Spring Meetings

Six KMA Trustee Districts have planned annual meetings featuring a slide presentation on Association activities by Henry B. Asman, M.D., Louisville, KMA president, according to the districts' trustees.

At press time, plans had been made by the Tenth District to meet April 8 at the Imperial House, Lexington. In addition to Doctor Asman's talk, John Stewart, M.D., Frankfort, was asked to speak on KEMPAC. The Eighth District had planned an April 10 meeting at Devou Memorial Building in Covington to which the physicians' wives had been invited.

The Fifteenth District will have a meeting April 16 in Manchester preceded by an afternoon scientific program. Other districts planning meetings include the Thirteenth May 6 in Ashland, the Fourteenth May 7 tentatively in Pikeville, and the Twelfth District June 11 in Somerset. Physicians in all districts planning spring sessions will receive letters outlining program details.

Topic of UK Radiology Symposium To Be Bone and Joint Disease

"Current Concepts in Bone and Joint Disease" will be the topic of a symposium April 29 to May 2 sponsored by the department of radiology in cooperation with the departments of orthopedics and pathology of the University of Kentucky Medical Center, according to Harold D. Rosenbaum, professor and chairman of the department.

Subjects to be included in the four-day conference are arthritides, trauma and chondrodysplasias. With emphasis on new or controversial material, a one-day panel discussion will cover nuances of a variety of proven cases.

A distinguished visiting faculty will include nationally prominent speakers. Staff members of the University of Kentucky College of Medicine will also participate in the discussions.

UL, Arthritis Foundation Plan Rheumatic Diseases Conf.

The Fifth Annual Rheumatic Disease Symposium, sponsored by the University of Louisville School of Medicine and the Kentucky Chapter of the Arthritis Foundation, will be April 10 in the Louisville General Hospital's Rankin Amphitheater, according to David H. Neustadt, M.D., Louisville, chief of the school's section on rheumatic diseases.

The full-day conference, entitled "What's New" in Rheumatic Diseases, will include discussions of recent advances in diagnosis and treatment of rheumatoid arthritis in adults and children, osteo-arthritis, crystal induced synovitis, special forms of periodic arthritis and new surgical approaches to arthritis. Audience participation in panel discussions will be encouraged, Doctor Neustadt said.

J. William Hollingsworth, M.D., chairman of the University of Kentucky Medical Center's department

of medicine, will be included among the nationally prominent authorities on the symposium's guest faculty. Further information may be obtained from the Symposium Program Committee, Kentucky Arthritis Foundation, 209 Speed Bldg., Louisville, Ky. 40202.

Mr. Mahoney Joins KMA Staff In Field Services Division

Jerry E. Mahoney, Frankfort, Kentucky's first director of community development, joined the staff of the Kentucky Medical Association March 1 as assistant director of field services. In this capacity, Mr. Mahoney will work closely with Director Gilbert Armstrong in the areas of legislative activities, governmental medical programs and liaison of the Headquarters Office with members throughout the state.



Mr. Mahoney

Before coming to KMA, Mr. Mahoney served as president of Community Development Associates, Inc. consulting firm and prior to holding that office as executive vice-president of the Frankfort—Franklin County Chamber of Commerce. He was elected to the Frankfort City Commission in November, 1967, and took office January 1, 1968 for a two-year term.

A graduate of Transylvania College and an active participant in community affairs, Mr. Mahoney is a member of the Frankfort-Franklin County Chamber of Commerce, former member of the Mayor's Advisory Committee, past fund drive chairman and past president of the Franklin County United Fund. He was chosen "Outstanding Young Man of Franklin County in 1966" by the Jaycees. Mr. Mahoney is married and has three children.

Fourth, Seventh KMA Districts Hear Dr. Asman at Meetings

Henry B. Asman, M.D., Louisville, KMA president, discussed various activities of the Association with carefully prepared slide presentations at the annual meetings of the Fourth and Seventh Trustee Districts January 30 and February 27 respectively.

The program of the Fourth District, which met in the Old Talbott Tavern, Bardstown, also featured a discussion of Comprehensive Health Planning in Kentucky by Strawn W. Taylor, director of the state's CHP Program.

David B. Stevens, M.D., Lexington, outlined the activities and plans of KEMPAC at the Seventh District's meeting at the Ramada Inn, Frankfort.

Ob-Gyn Society Schedules Mtg. April 11-12 in Louisville

Luigi Mastroianni, Jr., M.D., professor and chairman of the department of obstetrics and gynecology at the University of Pennsylvania School of Medicine, will be one of four guest speakers to participate in the program of the annual spring meeting of the Kentucky Obstetrical and Gynecological Society April 11-12 at Stouffer's Louisville Inn, according to Walter M. Wolfe, M.D., Louisville, secretary-treasurer of the Society.

Doctor Mastroianni, a 1950 graduate of the Boston University School of Medicine, is a diplomate of the American Board of Obstetrics and Gynecology, a fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists and former chairman of the advisory committee on primate centers, National Institutes of Health. He will discuss "Physiological Basis for the Treatment of Tubal Disease."

Other participants and their topics include Duncan Reid, M.D., professor and chairman of the Harvard Medical School's ob-gyn department, "Diabetes in Pregnancy;" Robert Rutherford, M.D., associate clinical professor of obstetrics and gynecology, University of Washington School of Medicine, "Psychogenic Factors in Infertility"; and William Q. Ascari, M.D., director of clinical rsearch for the Diagnostics ORTHO Research Foundation, "Rh Immune-globulin and Its Role in the Presence of RH Hemolytic Diseases of the Newborn."

Pathologists To Meet April 10

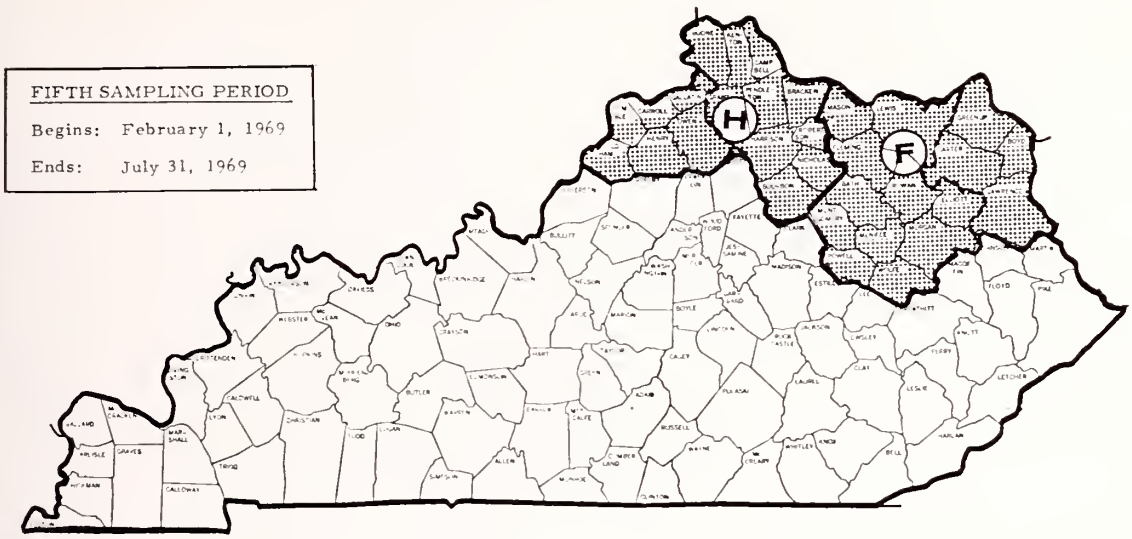
The annual spring meeting of the Kentucky Society of Pathologists will be a joint session with the Greater Cincinnati Society of Pathologists April 10 at the Cincinnati Academy of Medicine, according to George R. Tanner, M.D., Ft. Thomas, program chairman.

Following a dinner meeting, beginning at 6:45 p.m., Robert H. Heptinstall, M.D., Johns Hopkins University School of Medicine, will discuss "Focal Glomerulonephritis". Doctor Heptinstall, a nationally recognized authority on kidney diseases, is the author of a well-known book on this subject.

Lex. Conf. To Have Ob-Gyn Spkr.

A discussion of "The Graphic Analysis of Normal and Abnormal Labor" by J. Robert Willson, M.D., professor and chairman of the department of obstetrics and gynecology at the University of Michigan Medical Center, Ann Arbor, will be a highlight of the Lexington Clinic Conference April 3, according to James W. Bard, M.D., Lexington, program chairman.

Other features of the conference will include the annual Carl Fortune lecture by Edmund Pellegrino, M.D., Stony Brook, N.Y., and a luncheon address by Francis M. Massie, M.D., Lexington. (See February *Journal* for details.)



Area subject to ACIR study of accidents resulting in injury or death to an occupant of a 1967, 1968 or 1969 model passenger car.

Auto Crash Research Program Enters Fifth Phase in Ky.

With the goal of making automobiles safer, the Kentucky-Cornell Automotive Crash Injury Research Program (ACIR) began its fifth six-month study phase February 1 in Kentucky. The current program will study the nature and specific causes of injuries sustained by occupants of recent model passenger cars in rural area accidents.

If you are a physician in one of the 31 counties included in the study, you may be asked to assist in the data collection project by providing information on a special report form concerning injuries or deaths of occupants in passenger cars of the last three years model. The forms will be provided by a state police officer.

Designed to reduce deaths and injuries in future auto accidents, the program is sponsored by KMA, the Kentucky State Department of Health, the Kentucky Hospital Association and the Kentucky State Police in cooperation with Cornell University. William K. Keller, M.D., Louisville, KMA Highway Safety Committee chairman, urges the cooperation of all physicians in the 31-county area.

The counties involved in the current study are Bath, Boone, Bourbon, Boyd, Bracken, Campbell, Carroll, Carter, Elliott, Fleming, Gallatin, Grant, Greenup, Harrison, Henry, Kenton, Lawrence, Lewis, Mason, Menifee, Montgomery, Morgan, Nicholas, Oldham, Owen, Pendleton, Powell, Robertson, Rowan, Trimble and Wolfe.

KIMA To Meet March 21-22

The spring meeting of the Kentucky Industrial Medical Association March 21-22 in Lexington will feature a tour of the IBM Plant arranged by John E. Trevey, M.D., Lexington, the plant's medical director and KIMA president-elect, according to Gradie R. Rountree, M.D., secretary-treasurer.

The scientific program will be held at IBM on the afternoon of March 21 and will continue March 22 with a morning session at the Imperial House. Some of the participants and their topics will be Cary M. Blaydes, M.D., Lexington, "Coronary Care Prior to Hospitalization;" David B. Stevens, M.D., Lexington, "Medical Quackery;" and John E. Eckerle, M.D., Louisville, "Alcoholism in Industry."

Exhibitors Urged To Make Plans

T. R. Marshall, M.D., chairman of the KMA Scientific Exhibits Committee, urges all physicians interested in presenting scientific exhibits at the 1969 KMA Annual Meeting to make plans and application to do so. Exhibits need not be expensive or professionally constructed, but should have a good subject and be of teaching value.

This year's Annual Meeting will be held at the Louisville Convention Center, September 23-25. A scientific exhibit application appears on page 198 of this issue. For further information, please contact the KMA Headquarters Office.





Hot under the collar...

high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

In Memoriam

BENJAMIN D. CHOATE, M.D.
Louisville
1879-1969

Benjamin D. Choate, M.D., 89, a Louisville physician for more than 50 years, died January 26 at his home. Doctor Choate graduated from the University of Louisville School of Medicine in 1902 and served in both World War I and World War II. He was a member of the Southern Medical Association and a past president of the Army-Navy Club.

EDWIN S. MIDDLESTADT, M.D.
Louisville
1907-1969

Edwin S. Middlestadt, M.D., 61, a Louisville physician since 1946, died January 29 at his home. Doctor Middlestadt graduated from the University of Louisville School of Medicine in 1935 and served as a major in the Army during World War II in the Southwest Pacific. He was on the staff of SS. Mary & Elizabeth Hospital and Methodist Evangelical Hospital.

VERNON D. PETTIT, M.D.
Paducah
1912-1969

Vernon D. Pettit, M.D., 55 a pathologist at Western Baptist Hospital, Paducah, died February 3 at his home. Death was attributed to a heart attack. A 1939 graduate of the University of Tennessee School of Medicine, Doctor Pettit was a fellow of the American College of Pathology, a member of the American Board of Pathologists, the Southern Medical Association, and the Kentucky Pathology Society.

WILLIAM L. TYLER, SR., M.D.
Owensboro
1875-1969

William L. Tyler, Sr., M.D., 93, an Owensboro physician for 60 years, died January 3 at the Owensboro-Daviess County Hospital following a long illness. Doctor Tyler graduated from the University of Louisville School of Medicine in 1904. He was a past president of the Daviess County Medical Society and the Daviess County Health Department Board.

Achromycin V
250 mg. capsules

ACHROMYCIN® V
TETRACYCLINE HCl
Lederle
4810-9

NOW LEASING

Doctors Place, Inc.
309 Shelby Street
Frankfort, Kentucky

Professional and Economic Opportunity

Very latest in Modern Luxury Office Suites

For Information
Call Area Code 502 223-1027
or write Box 344
Frankfort, Kentucky 40601

Anesthesiologists Elect Officers

The Kentucky Society of Anesthesiologists named Dean Morrow, M.D., Lexington, president-elect at a January 12 meeting in Louisville. H. C. Bradley, Jr., M.D., Louisville, was installed as president, succeeding Fred C. Hauck, M.D., Owensboro.

Other officers elected by the Society include Richard Salsitz, M.D., Louisville, secretary-treasurer, and Peter Bosomworth, M.D., Lexington, delegate to the American Society of Anesthesiologists.

Health Appointments Announced

Governor Louie B. Nunn recently announced the appointment of David B. Stevens, M.D., Lexington, and the reappointment of Dexter Meyer Jr., M.D., Covington, to the state Board of Health. Doctor Stevens succeeds Branham B. Baughmann, M.D., Frankfort, who had served two full terms and was not eligible for re-election.

Oris Aaron, M.D., Columbia, was appointed by the Governor to the Advisory Council for Health Facilities. Doctor Aaron succeeds John M. Allen, M.D., Lexington.

Mr. Dixon Retires February 28

Raymond F. Dixon, former KMA staff member and past president of the Kentucky Public Health Association, retired February 28 after 47 years of service in federal and state health fields. At the time of his retirement he was director of the Division of Health Manpower Educational Services of the National Institutes of Health.

From 1948 to 1953, Mr. Dixon was assistant secretary to KMA and associate editor of *The Journal.* He also served as assistant secretary for medical licensure, State Board of Health, and as assistant secretary for the Kentucky Medical Research Commission.

TWO INTERNISTS—Board Eligible or Certified, wanted by multi-specialty group in Central Texas Associated with 100-bed hospital; $20-$24,000 annual salary; early partnership; no investment. Write G. H. Wahle, Jr., M. D. King's Daughters Clinic, Temple, Texas, or call collect 817 778-5501.

County Society Reports

FAYETTE

The regular monthly meeting of the Fayette County Medical Society was held February 11 at the Imperial House, Lexington, with David A. Hull, M.D., Lexington, Society president, presiding. The Society adopted a statement endorsing health aspects of current annexation action which follows:

"The Fayette County Medical Society has studied the current plan of annexation initiated by the City of Lexington as proposed by Spindletop Research, Inc. Inadequate sanitary systems throughout the metropolitan area have resulted in a serious potential health hazard by pollution of surface and sub-surface water. The city's plan for provision and expansion of a sanitary sewer system will rectify the problems that have been created and reduce considerably the development of additional hazards. Control of these hazards is essential for the health of the community. The Fayette County Medical Society therefore endorses the health aspects of the annexation action."

County Societies Name Officers For 1969 Associational Year

The following physicians have been named officers of their county medical societies for the coming year, according to the records of the membership department February 15.

Bell

President: Ralph R. Robinson, M.D., Middlesboro
Vice-President: Emanuel H. Rader, M.D., Pineville
Secretary-Treasurer: Reginald S. Lowe, Jr., M.D., Middlesboro

Casey

President: George Sweeney, M.D., Liberty
Vice-President: Lewis E. Wesley, M.D., Liberty
Secretary: Cathryn V. Cornett, M.D., Liberty
Delegate to KMA: Lewis E. Wesley, M.D.

Fayette

President: David A. Hull, M.D., Lexington
Vice-President: Leslie W. Blakey, M.D., Lexington
Secretary-Treasurer: J. G. Wilhite, M.D., Lexington
Delegates to KMA: J. F. Berry, M.D., Lexington
Leslie W. Blakey, M.D.
M. C. Blaydes, M.D., Lexington
Peter P. Bosomworth, M.D., Lexington
T. R. Bryant, M.D., Lexington
N. Lewis Bosworth, M.D., Lexington
W. L. Burke, M.D., Lexington
David A. Hull, M.D.
Richard B. McElvein, M.D., Lexington
Alternates: D. E. Edger, M.D., Lexington
F. B. Wells, M.D., Lexington

Fleming

President: W. A. Graham, M.D., Flemingsburg
Vice-President: S. W. Gehring, M.D., Flemingsburg
Secretary: Ben F. Allen, M.D., Flemingsburg
Delegate to KMA: S. W. Gehring, M.D.
Alternate: R. W. Fidler, M.D., Flemingsburg

Floyd

President: William B. Cook, M.D., Prestonsburg
Vice-President: James Holbrook, M.D., Prestonsburg
Secretary-Treasurer: Russell Hall, M.D., Prestonsburg
Delegate to KMA: Lowell Martin, M.D., Martin
Alternate: James Holbrook, M.D.

Grant

President: Frederick Scroggin, M.D., Dry Ridge
Vice-President: Claude C. Waldrop, M.D., Williamstown
Secretary-Treasurer: Darl B. Shipp, M.D., Dry Ridge
Delegate to KMA: Darl B. Shipp, M.D.
Alternate: Frederick Scroggin, M.D.

Harlan

President: James D. Foley, M.D., Loyall
Vice-President: James K. Hurlocker, M.D., Harlan
Secretary-Treasurer: Wilfred F. Jones, Jr., M.D., Harlan
Delegates to KMA: Henry Evans, M.D., Harlan
R. Smith Howard, M.D., Harlan
Alternates: Gilbert L. Hamilton, M.D., Harlan
Walter H. Stepchuck, M.D., Harlan

Henderson

President: Julian B. Cole, M.D., Henderson
Vice-President: Clarence J. McGruder, M.D., Henderson
Secretary-Treasurer: Walter L. O'Nan, M.D., Henderson
Delegates to KMA: Kenneth Eblen, M.D., Henderson
Charles C. Kissinger, M.D., Henderson
Alternates: Molloy G. Veal, M.D., Henderson
Wayne C. Liles, M.D., Henderson

Hopkins

President: Joseph Milburn, M.D., Madisonville
Vice-President: Charles Fisher, M.D., Madisonville
Secretary-Treasurer: K. P. Haywood, M.D., Earlington
Delegates to KMA: Loman C. Trover, M.D., Madisonville
Faull S. Trover, M.D., Madisonville
Alternates: Charles Fisher, M.D.
K. P. Haywood, M.D.

Johnson

President: Maurice M. Hall, M.D., Paintsville
Vice-President: John W. Turner, M.D., Paintsville
Secretary-Treasurer: Paul B. Hall, M.D., Paintsville
Delegate to KMA: Glenn R. Powell, M.D., Paintsville
Alternate: John W. Turner, M.D.

Knox

President: W. P. Clifton, M.D., Barbourville
Vice-President: Francis X. Sommer, M.D., Barbourville
Secretary-Treasurer: Harold L. Bushey, M.D., Barbourville
Delegate to KMA: Harold L. Bushey, M.D.
Alternate: T. R. Davies, M.D., Barbourville

Lincoln

President: Howard I. Frisbie, M.D., Stanford
Vice-President: T. J. Wright, M.D., Stanford
Secretary-Treasurer: Edward C. Bowling, M.D., Stanford
Delegate to KMA: Howard I. Frisbie, M.D.
Alternate: T. J. Wright, M.D.

Logan

President: J. P. Glenn, M.D., Russellville
Vice-President:Jack B. Holt, M.D., Russellville
Secretary-Treasurer: C. V. Dodson, M.D., Russellville

Madison

President: Robert L. Rice, M.D., Richmond
Vice-President: Maxwell C. Kimball, M.D., Richmond
Secretary-Treasurer: Linda S. Fagan, M.D., Richmond

McCracken

President: D. L. Boucher, M.D., Paducah
Vice-President: William Hosbach, M.D., Paducah
Secretary-Treasurer: Frank Crawford, Jr., M.D., Paducah
Delegates to KMA: Burton Haley, M.D., Paducah
Eugene Sloan, M.D., Paducah
Alternates: D. L. Boucher, M.D.
Chester Blanton, M.D., Paducah

Mercer

President: Frank Whalen, M.D., Harrodsburg
Vice-President: E. H. John, M.D., Harrodsburg
Secretary-Treasurer: C. B. VanArsdall, Jr., M.D., Harrodsburg
Delegate to KMA: Frank Whalen, M.D.
Alternate: J. S. Baughman, III, M.D., Harrodsburg

Monroe

President: Wendell F. Hurt, M.D., Tompkinsville
Vice-President: Kenneth Crabtree, M.D., Gamaliel
Secretary-Treasurer: John Marsh, M.D., Gamaliel
Delegate to KMA: J. Jack Martin, M.D., Tompkinsville
Alternate: James E. Carter, M.D., Tompkinsville

Montgomery

President: William H. McKenna, M.D., Mt. Sterling
Vice-President: Lon E. Roberts, M.D., Mt. Sterling
Secretary-Treasurer: Robert J. Salisbury, M.D., Mt. Sterling
Delegate to KMA: Robert J. Salisbury, M.D.
Alternate: Don C. McFadden, M.D., Mt. Sterling

Nelson

President: Charles B. Spalding, M.D., Bardstown

Vice-President: Kenneth L. Stinnette, M.D., Bardstown

Secretary-Treasurer: James M. Millen, M.D., Bardstown

Delegate to KMA: Kenneth L. Stinnette, M.D.

Alternate: Tyre G. Forsee, M.D., Bardstown

Perry

Co-President: Keith Cameron, M.D., Ary

Co-President: Donald L. Martin, M.D., Ary

Vice-President: J. F. Gilbert, Jr., M.D., Hazard

Secretary-Treasurer: C. C. Rutledge, M.D., Hazard

Delegate to KMA: Keith Cameron, M.D.

Whitley

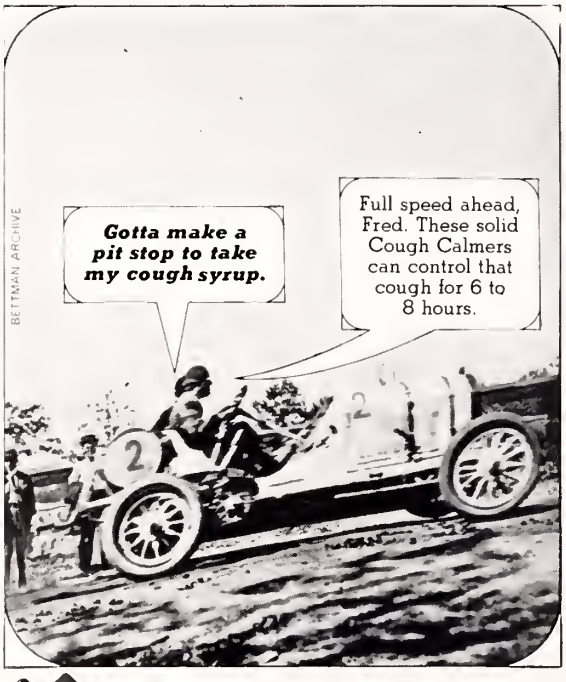
President: Harry A. Hamilton, M.D., Corbin

Vice-President: Leonidas X. Brown, M.D., Williamsburg

Secretary-Treasurer: Elmer G. Prewitt, M.D., Corbin

Delegate to KMA: Roemer D. Pitman, M.D., Williamsburg

Alternate: Lawrence U. Gilliam, M.D., Corbin



Robitussin-DM Cough Calmers

Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

KMA Committee Reports

Committee on Appalachian and OEO Programs

Frank M. Gaines, Jr., M.D., Louisville, Chairman

KMA Headquarters Office **November 21, 1968**

The Committee on Appalachian and OEO Programs met on November 21 to discuss present Kentucky OEO and Appalachian Health Programs, including the Appalachian Health Programs in 11 Southeastern Kentucky counties.

The Committee members visited the Park-DuValle Neighborhood Health Center in Louisville's West End, where they were given a tour of the facilities and were briefed on the projects being conducted and those scheduled when reconstruction of the facilities is completed.

Ad Hoc Committee for Improved Community Health

Irving F. Kanner, M.D., Lexington, Chairman

Hardin Memorial Hospital **December 4, 1968**
Elizabethtown

The KMA Ad Hoc Study Committee for Improved Community Health met recently at the Hardin Memorial Hospital, Elizabethtown. A "local action" committee in the Elizabethtown area is being formed under the sponsorship of the Hardin County Medical Society. This committee will determine the major health problems of the county and establish priorities for the improvement of community health.

Future plans call for the formation of a similar committee in the Owen County area.

University of Kentucky medical students are assisting this committee with reports from studies being made in selected communities.

McDowell House Board of Managers

Laman A. Gray, M.D., Louisville, Chairman

McDowell House Danville **December 18, 1968**

One of the major improvements voted on by the McDowell House Board of Managers at their last meeting was the installation of a new heating and air conditioning system, which is scheduled for this spring. The heating plant has deteriorated after 40 years of service, and the Committee was advised that air conditioning will aid in protection of the house and its antiques.

Other items considered by the Committee were the budget for the coming year, a review of the original blueprints of the home, additional insurance on the McDowell House and furnishings, and the replacement of a collapsed brick wall enclosing part of the grounds.

The third meeting of the Board of Managers for this Associational year was set for Wednesday, March 12, 1969.

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **December 19, 1968**

The Hospital Committee held its first meeting of the Associational year recently, and considered, among other things, reports on the "Dry Run" Accreditation Teams. These teams, composed of two physicians, a hospital administrator, and a medical records librarian, visit hospitals requesting their services prior to a visit by the Joint Commission on Hospital Accreditation.

The Committee made recommendations to the KMA Board of Trustees regarding staffing of emergency rooms and the enforcement of hosiptal licensure regulations.

Comprehensive health planning was also discussed, and the Committee expressed the hope that Kentucky physicians would take the lead in setting up the local Comprehensive Health Planning Councils throughout the state.

Communication and Health Education

N. Lewis Bosworth, M.D., Lexington, Chairman

KMA Headquarters Office **January 9, 1969**

The KMA Communications and Health Education Committee met in January to finalize the next two KMA Orientation Courses, which will be held in conjunction with the Interim and Annual Meeting sessions. A total of 339 physicians have attended the seven courses to date, with an additional 79 eligible to attend the program to be given at the Interim Meeting in March.

The Committee also made recommendations concerning KMA's participation at the Kentucky Educational Association's Annual Meeting, and approved a request that physicians be asked to display promotional aids for health career recruitment in their offices and clinics.

Ad Hoc Study Committee for Improved Community Health

Irving F. Kanner, M.D., Lexington, Chairman

The Smith House, Owenton **January 15, 1969**

The KMA Ad Hoc Study Committee for Improved Community Health met recently with Owen County physicians to plan the establishment of a local action committee for improved community health. Studies have been made in both Owen and Hardin Counties with the assistance of senior medical students in an effort to determine the health needs of both communities.

Methods used in solving individual community problems will serve as a demonstration for other communities with similar difficulties. Future plans of the Committee are to coordinate efforts and results of the Owen and Hardin County projects.

Educational Television Committee

William P. VonderHaar, M.D., Louisville, Chairman

Kentucky Educational Television Studios **January 22, 1969**
Lexington, Kentucky

The KMA Educational Television Committee traveled to the studios of the Kentucky Educational Television Authority in Lexington for the first meeting of the year. Representatives from a number of paramedical groups were invited in an effort to solicit their opinions as to the type of programs that would be beneficial to their particular groups as well as to physicians.

After touring the ETV facilities, the Committee discussed the various methods available to them through ETV for continuing medical education and discussed plans to work with KETV to sponsor two or more evening programs aimed at continuing medical education for Kentucky physicians.

School Health, Physical Education and Medical Aspects of Sports

O. B. Murphy, M.D., Lexington, Chairman

KMA Headquarters Office **January 23, 1969**

The development of a format for all county society school health chairmen was the number one agenda item for the Committee at this meeting. The Committee felt that by developing such a format, there will be greater cooperation and concentration of effort on the part of school health committees at both state and county levels in insuring proper medical supervision of all physical education activities.

Other items included the presentation of an exhibit at the 1969 Annual Meeting of the Kentucky Education Association on drug abuse, sex education, physical fitness and medical aspects of sports. The Committee plans a panel presentation during the 1969 KMA Annual Meeting in September.

Attend the

KMA

Interim Meeting

March 26-27

Continental Inn

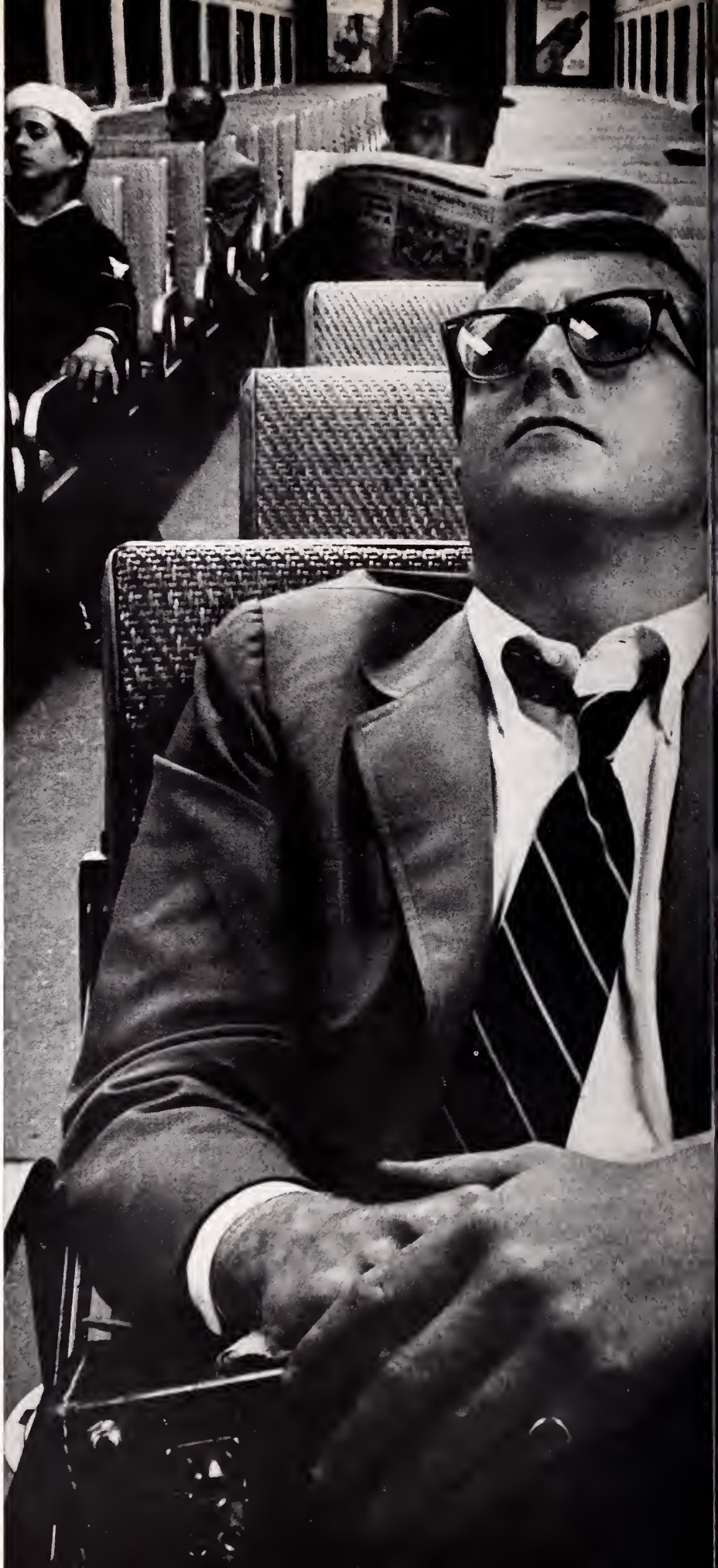
Lexington

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal (persistent palpitations)



ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

B.A. (*cum laude*)...V.P. (at thirty-two)...symbols that illuminate the quality of a life...the satisfactions of achievement, as well as its price...the pressures and stresses that can often create cardiac manifestations of psychic tension. For this kind of patient—with no demonstrable pathology—consider the singular benefits of Valium (diazepam).

With its pronounced calming action, Valium can relieve psychic tension promptly, attenuating its somatic signs and symptoms. Further, Valium is distinctly useful when somatic and depressive symptomatology (secondary to psychic tension) coexist. And Valium is generally well tolerated; in proper maintenance dosage, it seldom dulls the senses or interferes with functioning.

When psychic tension-related insomnia appears, an *h.s.* dose added to the *t.i.d.* schedule helps promote sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets *t.i.d.* or *q.i.d.*

to help relieve psychic tension
and its somatic symptoms

Case Report of a Paint-Thinner Sniffer

(Continued from page 197)

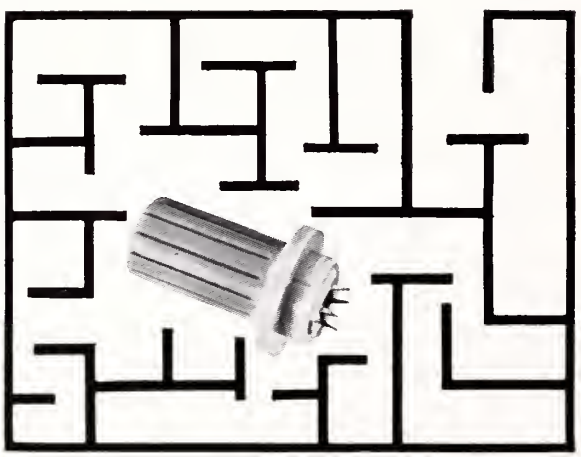
tient thought he was a lost child and wanted to be loved. The patient denied morbid ideas. There was no evidence of psychosis. Psychological tests revealed a character disorder with antisocial behavior. Routine laboratory work fell within normal limits. Physical examination revealed a healthy young man. The psychiatric diagnosis was sociopathic personality disorder, anti-social reaction.

Acknowledgment

The author wishes to thank Doctor Robert DeBurger for reviewing the manuscript prior to its submission.

References

1. Brozovsky, Morris, M.D., et al., Glue Sniffing in Children and Adolescents, *New York State Med. J.*, 1965, p. 1384.
2. Tolan, E.J., M.D., Model Psychosis produced by Inhalative of Gasoline Fumes, *American J. of Psychiatry*, 1964, p. 757.
3. Nylander, I., Thinner Addiction in Children and Adolescents, *ACTA Paedopsychiatrica*, 1962, p. 273.
4. Bartlett, S., M.D., Glue Gasoline "Sniffing," the Addiction of Youth, A Case Report, *Missouri Medicine*, 1966, p. 270.
5. Glaser, Helen, M.D., Glue Sniffing in Children, *J.A.M.A* July 28, 1962, p. 300.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

NEWS ITEMS

William D. Pratt, M.D., a general practitioner, is practicing in association with the Daniel Boone Clinic in McDowell. A 1967 graduate of the University of Kentucky College of Medicine, Doctor Pratt completed his internship at Riverside Methodist Hospital, Columbus, Ohio.

Frank Whalen, Jr., M.D., a general practitioner, is practicing in Harrodsburg in association with James Keightley, M.D. and Bacon Moore, M.D. Doctor Whalen graduated from the University of Louisville School of Medicine in 1965 and completed his internship at St. Elizabeth Hospital, Dayton, Ohio.

Frederick P. Shepherd, M.D., Louisville, joined Arthur J. Shulthise, M.D., Louisville, in the general practice of medicine February 1. Doctor Shepherd had practiced for a number of years with the E. I. duPont de Nemours Company, Louisville.

John F. Simonds, M.D., a child psychiatrist, is a full-time faculty member at the University if Louisville School of Medicine. A 1959 graduate of Georgetown University, Doctor Simonds completed his internship at Providence Hospital, Washington, D.C., and his residency training at Ohio State University Hospital and the Lafayette Clinic.

Robert L. Strawn, M.D., an ophthalmologist, is practicing in association with Dexter Meyer, Jr., M.D. and John A. Reeves, M.D. in Covington. Doctor Strawn graduated from the University of Cincinnati Medical School in 1962. He completed his internship in San Francisco, Calif. hospitals and his residency training at Cincinnati General Hospital.

George W. White, III., M.D., a pediatrician, is practicing at the Neighborhood Health Center, Louisville. A 1964 graduate of Meharry Medical College, Doctor White completed his internship and residency training at the George W. Hubbard Hospital.

Reginald S. Lowe, Jr., M.D., an ophthalmologist, is practicing in association with the Daniel Boone Clinic, Middlesboro. Doctor Lowe graduated from Tulane University Medical School in 1959. He completed his internship at University of Mississippi hospitals and his residency training at Walter Reed General Hospital.

James B. Zimmerman, M.D., a radiologist, is practicing in association with Gene N. Combs, M.D. in Pikeville. Doctor Zimmerman graduated from the University of Maryland Medical School in 1958. He completed his internship and residency training at Miami Valley Hospital and has practiced in Dayton. Ohio.

Jerry M. Bryson, M.D., an opthalmologist, is practicing in association with T. D. Pruitt, M.D. in Harlan. Doctor Bryson graduated from the University of Tennessee Medical School in 1962. He completed his internship at Baptist Memorial Hospital, Memphis, Tenn., and his residency training at the University Hospital, Ann Arbor, Mich.

Frederick E. DePriest, M.D., a general practitioner, is associated with the Daniel Boone Clinic in Harlan. Doctor DePriest is a 1936 graduate of the University of Arkansas Medical School and has practiced in Shreveport, La., and Houston, Texas.

Charles D. Eversole, M.D., a radiologist, is practicing in association with Doctors Walsh, Adair, Garrett and Janney in Covington. Doctor Eversole graduated from the University of Louisville School of Medicine in 1960. He completed his internship at Parkland Memorial Hospital in Dallas, Texas and his residency training at the University of Cincinnati. He is a part time instructor at the University of Cincinnati.

Gerald L. Moore, M.D., a psychiatrist, is practicing in association with Warren Cox, M.D., Arthur Kasey, M.D. and George Doyle, M.D. in Louisville. Doctor Moore graduated from Emory Medical School in 1962 and completed his internship and residency training at Louisville General Hospital.

Murray F. Ables, M.D., a psychiatrist, is now a full-time faculty member at the University of Kentucky College of Medicine. Doctor Ables graduated from the University of Wisconsin Medical School in 1960. He was formerly with the Veterans Administration Hospital, Lexington.

Max C. Salb, M.D., a general practitioner, is now on the staff of the Kentucky State Prison Hospital at Eddyville. A 1929 graduate of the Indiana University School of Medicine, Doctor Salb previously practiced for 36 years at Indianapolis, Ind.

Roberto Garcia-Rivera, M.D., a general practitioner, has opened an office in Augusta. Doctor Garcia-Rivera graduated from the University of Havana in 1951 and practiced previously in Havana, Cuba.

Maxwell Kimball, M.D. a general practitioner, has opened an office in Richmond. His practice will include obstetrics. Doctor Kimball graduated from the University of Kentucky College of Medicine in 1964 where he also interned and completed his residency training in anesthesiology. Doctor Kimball has practiced in Lexington and Stanford.

Roy J. Vermillion, M.D., a surgeon, is practicing in association with L. F. Beasley, M.D., in Franklin. Doctor Vermillion graduated from the University of Tennessee Medical School in 1961. He completed his internship and residency training in Nashville and has practiced in Fayetteville, Tenn.

John G. Stober, Sr., M.D., a general practitioner, is associated with Doctors Peters and Bishop in Jeffersontown. A 1967 graduate of the University of Louisville School of Medicine, Doctor Stober completed his internship at St. Joseph Infirmary.

Lafayette G. Owen, M.D., a dermatologist, is associated with Doctors Fliegelman and Molloy in Louisville. Doctor Owen graduated from the University of Louisville School of Medicine in 1961. He completed his internship at St. Joseph's Infirmary and his residency training at Baylor College of Medicine.

H. Martin Blacker, M.D., a neurosurgeon, is now a full-time faculty member at the University of Kentucky Medical Center. Doctor Blacker graduated from the University of Nebraska Medical School in 1959. He completed his internship and residency training at the Johns Hopkins Hospital and recently finished a post-doctoral fellowship in neurophysiology and stereotaxic surgery at the University of Wisconsin and Notre Dame Hospital, Montreal.

John W. Garden, M.D., an ophthalmologist, is now practicing in Lexington. Doctor Garden graduated from the University of North Carolina Medical School in 1961. He completed his internship at Bellevue Hospital and his residency training at Yale University.

Russell L. Travis, M.D., a neurological surgeon, is practicing in association with Joseph Keith, M.D., in Lexington. Doctor Travis graduated from the University of Louisville School of Medicine in 1962. He completed his internship at Louisville General Hospital and his residency training at the Medical College of South Carolina.

Glynn E. Reynolds, M.D., a general practitioner, has opened an office in Richmond. A 1967 graduate of the University of Kentucky College of Medicine, Doctor Reynolds completed his internship at Kettering Memorial Hospital, Kettering, Ohio.

James M. McEntyre, M.D., an ophthalmologist, is now a full-time faculty member at the University of Kentucky College of Medicine. A 1959 graduate of the Medical College of Georgia, Doctor McEntyre completed his internship at the U.S. Naval Hospital, Jacksonville, Fla. and his residency training at Jefferson Medical College, Philadelphia, Pa. and as an exchange resident at the University of Puerto Rico.

Glenn Marsh, M.D., a dermatologist, has opened an office in Lexington. A 1961 graduate of Emory University Medical School, Doctor Marsh completed his internship at Fitzsimons General Hospital and his residency training at Brooke General Hospital. He practiced previously in military hospitals during his 10 years of service in the U.S. Army.

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665.....President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660....Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123.....Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661.....Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211.....Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282.....Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552..Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340.....1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255.....1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362..1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231.....1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406.....1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751.....1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155....1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698.....1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357.....1969

Buyers Guide

MARCH BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Cancer Society 176
Bristol Laboratories 154
Burroughs Wellcome 211
Cabell Huntington Hospital 161
Campbell Soup 199
Doctors Place 223
Geigy Pharmaceuticals 212-213, 216, 220-222
General Leasing Corporation 171
Highland Hospital 233
Hynson, Westcott & Dunning 155
Kentucky Arthritis Foundation 169
King's Daughters Clinic 224
Lederle Laboratories 157, 161, 179-180, 223, 230, 233
Lilly, Eli & Company 184
McNeil Laboratories 181
Medical Protective Company 210
National Drug Company 168,175
Parke, Davis Company 165
Pitman-Moore Company 182-183
Poythress, Wm. P. Company 166, 168
Robins, A. H. Company 159, 177-178, 226
Roche Laboratories 170-171, 214-215, 228-229, 234
Searle, G. D. & Company 200-201
Smith, Kline & French 173
Southern Optical Company 210
Strasenburgh Laboratories 202
Warner Chilcott 163-164
Winthrop Laboratories 167
Wyeth Laboratories 206-207

—The lowest priced tetracycline—nystatin combination available—



HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

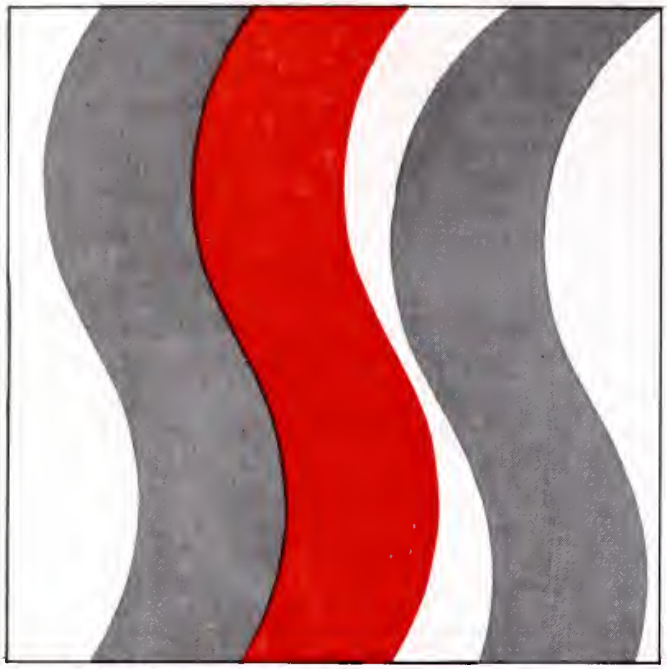
Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

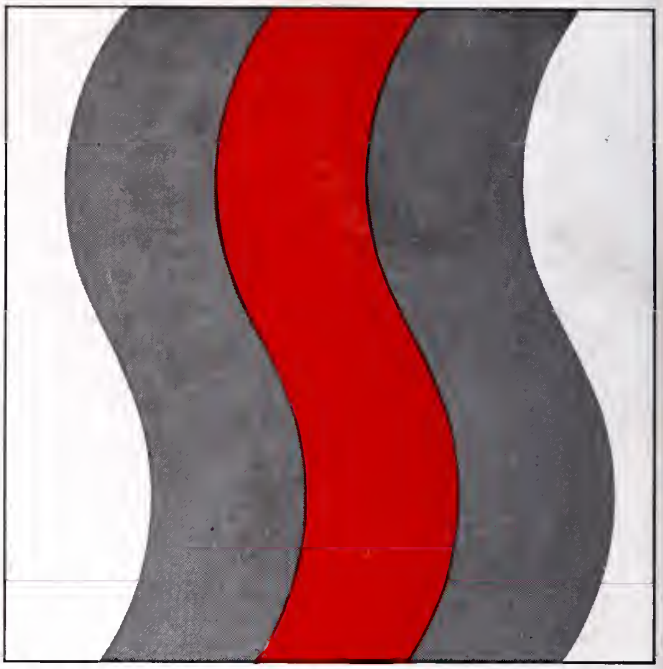
Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-253-2761



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

VOLUME 67 APRIL 1969 NUMBER 4

The Journal of The KENTUCKY Medical Association



COLLEGE OF

In This Issue

Reye's Syndrome: An Association with Influenza A Infection
Bryan D. Hall, M.D., Walter T. Hughes, Jr., M.D. and Donald Kmetz, M.D. 269

Fibroplastic Endocarditis with Eosinophilia (Loeffler's Endocarditis)
William C. Gaventa, M.D., Franklin G. Hoffman, M.D., F.A.C.P., and Walter L. Broghamer, M.D. 272

The Genesis and Treatment of Hyperadrenalism
Frank Glenn, M.D. 281

Special Article

CHP
George F. Brockman, M.D. 289

Introducing

What's New In Medical Progress 266

Complete Contents on page 238

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®

LIQUID/TABLETS

aluminum and magnesium hydroxides *plus* simethicone

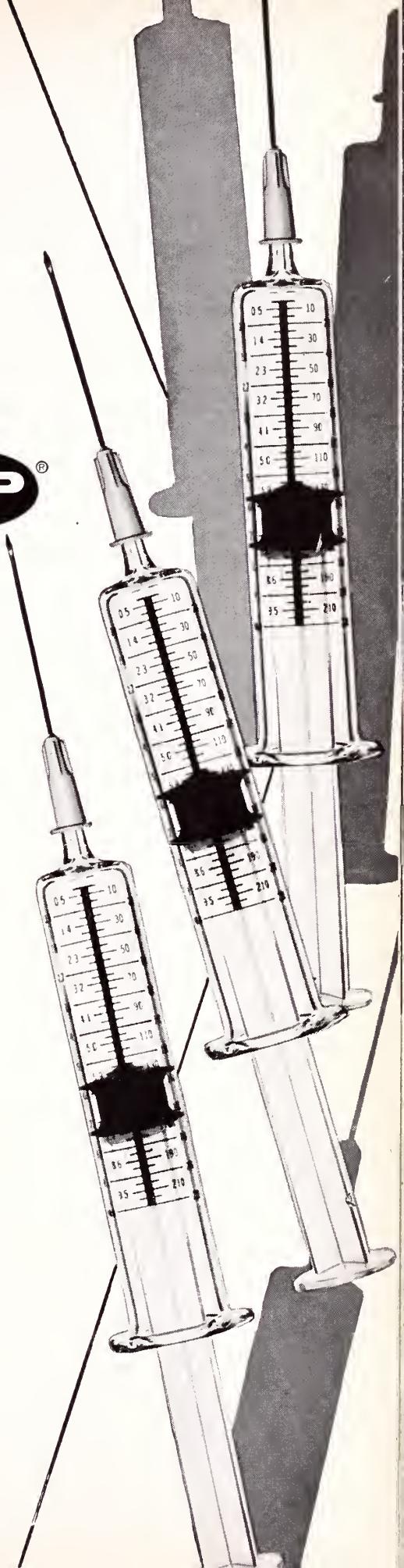
Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSP03)

BALTIMORE, MARYLAND 21201

Volume 67 • April 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Cae, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cax

• ASST. MANAGING EDITOR
Peggy Roberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussians
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Lauls O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Raddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D
Peggy J. Howard, M.D
Ray A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
John H Willard, M.D.

Term Expires July 1, 1969
Paul E. Lett, M.D.
David A. Orrihood, M.D.
Harry A. Hamilton, Jr., M.D.
Leslie W. Blakey, M.D.
Roymand J. Timmermon, M.D.
William H. Gillespie, M.D.
J. J. Sonne, M.D.
John L. Creech, Jr., M.D

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10.00—single copy 1.00
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Reye's Syndrome: An Association with Influenza A Infection
Bryan D. Hall, M.D., Walter T. Hughes, Jr., M.D. and Donald Kmetz, M.D. 269

Fibroplastic Endocarditis with Eosinophilia
William C. Gaventa, M.D., Franklin G. Hoffman, M.D., F.A.C.P., and Walter L. Broghamer, M.D. 272

The Genesis and Treatment of Hyperadrenalism
Frank Glenn, M.D. 281

SPECIAL ARTICLES

CHP
George F. Brockman, M.D. 289

EDITORIALS

Neglected Opportunity
Sam A. Overstreet, M.D. 292

SPECIAL FEATURES

In Memoriam 293

ORGANIZATION SECTION

KAGP Plans 18th Annual Meeting May 6-10 in Louisville 294
Mr. Handley, Guest of Surgeons, To Speak at UL Symposium 294
Surgeons To Hold Joint Mtg. May 16-17 in Somerset 294
Ky. Chapter Pediatricians Plan 11th Annual Spring Meeting 295
Annual Immunization Week Set May 4-10 in Kentucky 295
Kentucky TB Organizations Plan Meetings April 23 and 24 296
Kentucky Hospital Association To Meet April 21-24 296
Medical Assistants To Meet At Elizabethtown in May 296
HEW Chiropractic Report Summary Printed for Information 296

REGULAR FEATURES

President's Page 240
Insurance Page 242
Maternal Mortality Page 244
In The Books 250
Postgraduate Opportunities ..256
Medical Progress 266



He is a diabetic.
He is middle-aged.
When he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



These Things I Believe*

RECENTLY, when espousing a cause in which I was interested, a colleague remarked that I was usually crusading for something. I am not a crusader by nature or by plan but I have no hesitancy expressing myself on issues in which I have convictions.

I believe that therapeutic abortion is a medical problem. It is not and should not be a legal, political or religious issue. This would be purely permissive legislation that would force no one to do anything against his or her will. I believe the present law, enacted in 1910, should be revised.

I believe that the American Red Cross, with its Regional Blood Center in Louisville, needs a new, modern facility. This center serves 25 Kentucky counties. Its quarters are obsolete and inadequate. Physicians in Jefferson and the surrounding 25 counties should give of time and money to assure realization of this project.

I believe physicians must become members of the administrative boards of hospitals and become more involved in hospital affairs. The AMA and KMA have urged hospitals to place one or more physicians on their governing boards. The American Hospital Association passed a resolution recommending that hospitals bring physicians into their Board of Trustees. To my knowledge, few hospitals in Kentucky have implemented these recommendations of the AMA, KMA or AHA. No one can deny that hospital costs have soared. At the same time, wages paid many hospital employees are not competitive with government or industry. Doctors are too often blamed for all facets of health care and many believe that physicians establish and control all hospital policies. Care of the sick is our vocation. For the lay Board, it is an avocation. I believe we can be of great service to both hospital and patient if given the opportunity to participate at Board of Trustee level.

I believe the KMA policy in regard to cigarette advertising should be reconsidered. There is now little or no controversy as to the harmful effects of cigarette smoking. It is incongruous, indeed inconsistent and yes, even hypocritical for physicians to accept compensation from companies advertising and dispensing in the halls of a medical convention, a product that, by law, must be clearly and conspicuously labeled "— may be hazardous to your health". To my knowledge, no physician advises or prescribes cigarettes. All of our citizens, politicians included, look to doctors to lead in matters of health. All will respect us more if we take positive action and speak out on matters in which we are knowledgeable.

These are some things I believe; they do not necessarily represent the beliefs of all of your officers or of all members of your Board of Trustees.

EDWIN P. SOLOMON, JR., M.D.
KMA VICE-PRESIDENT

**This is the second in a series of articles written at the request of KMA President Henry B. Asman, M.D.*

An Open Letter from Kentucky BLUE SHIELD®[1] . . .

BLUE CROSS FOR HOSPITAL CARE

Blue Cross Hospital Plan, Inc.

452-1511 • 3101 BARDSTOWN ROAD • LOUISVILLE, KENTUCKY 40205

BLUE SHIELD FOR SURGICAL CARE

Kentucky Physicians Mutual, Inc.

Dear Doctor:

Like all busy men, you probably find it difficult to keep up with everything that's going on in today's changing world, perhaps even in your own specialty.

At Blue Shield we have several ways in which we try to keep you informed, but we know that despite our best effort, you may have questions about what we do and how or why we do it.

Maybe you find a certain billing procedure puzzling, or you have a question concerning our new Kentucky Blue Shield Usual and Customary Program. Maybe you'd simply like to invite our comment on Blue Shield or Blue Cross philosophy of operation.

So please drop a line to G. Douglas Southerland, Director of Professional Relations, if you have a question. We'll guarantee a prompt reply; or if you wish, one of our Professional Relations Representatives will visit you. We'll do our best to help you.

Garnett Sweeney, M.D.
Chairman, Blue Shield Board

J. Ed McConnell, President
Kentucky Blue Cross and Blue Shield

For more information, CONTACT our office nearest you

BLUE SHIELD®[1] BLUE CROSS®

®[1] KENTUCKY PHYSICIANS MUTUAL INC. BLUE CROSS HOSPITAL PLAN, INC. ®

3101 Bardstown Road • Louisville, Ky. 40205 • (502) 452-1511

®[1] Registered service marks of the National Association of Blue Shield Plans
® Registered service marks of the American Hospital Association



THE INSURANCE PAGE



Comprehensive Health Planning and Medicial Care Costs

The members of the 89th Congress are probably surprised by the broad, enthusiastic support which the "comprehensive health planning act" has generated among providers of health care. Organized medicine has been in the forefront in setting up community health planning agencies and more recently the American Hospital Association and the Blue Cross Association have voiced broad support for the concept and the program.

The Board of Governors of the National Blue Cross Association has pledged to put its resources behind comprehensive health planning at the national, state and local levels in order to help stem the tide of rising medical costs and at the same time help make better health care more readily accessible to all Americans.

Walter J. McNerney, president of the Blue Cross Association, who announced the board action, said that the appraisal and approval of all plans for new hospital facilities should be in terms of over-all community needs.

"To avoid costly duplication and needless overspending", he said, "there should also be a greater sharing of services and expensive equipment and a concentration on building more efficient and better-distributed hospitals."

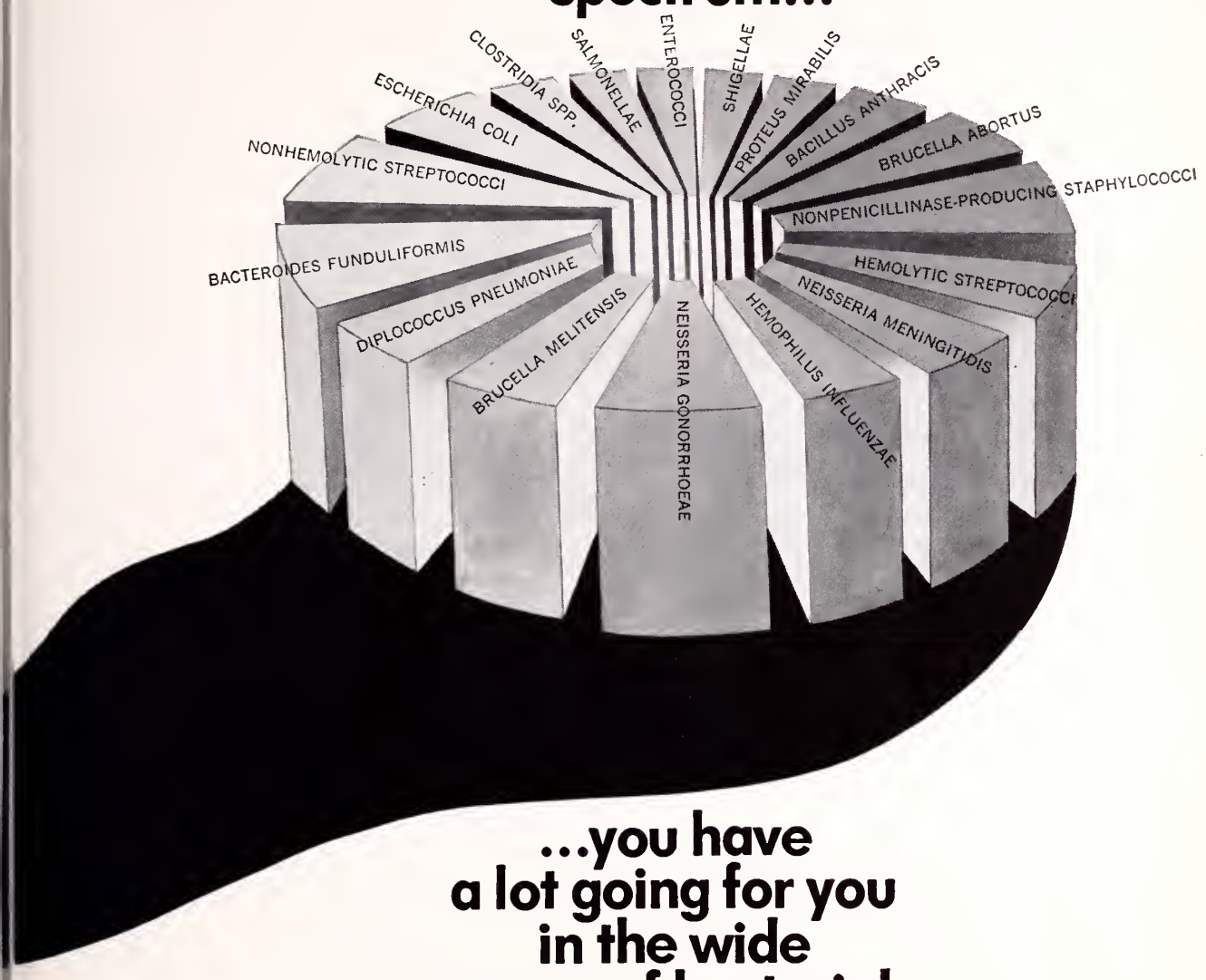
To act as a watchdog on the cost of medical care in the hospital on behalf of the public, the Blue Cross system would develop payment methods of its participating hospitals, which take into account and promote cooperation with local planning councils.

The American Hospital Association's House of Delegates recently approved an official policy statement that links re-imbursement of hospitals with area wide community health planning. This action followed a series of study sessions over a period of 18 months in which the statement was developed. "The community must provide for proper financing of its health care system and the health care system must accept on its part, the community's right to insist on proper planning".

With broad support from hospitals, insurers and doctors, it appears that the comprehensive health planning program is off to a good start. It should exert tremendous influence in shaping the direction of medical care in the future.

WILLIAM W. HALL, M.D.

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

Case 3-67. A 28-year-old married, white, gravida 3, para 2, who was under the care of a private physician, gave a history of taking C-Quens for several months prior to June 20, 1966. On June 24 an episode of uterine bleeding began, and the patient continued to spot until July 31, 1966, when she was admitted for dilatation and curettage with the presumptive diagnosis of dysfunctional bleeding. She gave no history of cramps, nausea or vomiting. Her only previous operation was for acute cholecystitis. On physical examination, the uterus was enlarged, and a positive Hegar's sign was elicited. A pregnancy test was positive. The blood pressure was 110/80. In view of these findings, she was discharged on August 1, with a diagnosis of pregnancy with bleeding of undetermined etiology.

The remainder of her prenatal course was normal until February 14, 1967, when she complained of some headache, double vision, and minor swelling of her legs and ankles. She called her physician complaining of the headache and asked to be seen. He gave her an appointment for the following day, but she failed to keep the appointment and did not return until February 19. She was now in the 37th week of pregnancy. Her blood pressure was 200/110, and a urinalysis showed 4+ albuminuria.

She was admitted at 9 a.m. on February 19 appearing acutely ill. There was marked choking of the disc of the left eye; the right eye appeared normal. The blood pressure was 175/110. There was no definite cardiac enlargement, but the heart rate was moderately rapid, and moist rales were heard throughout both lung fields. The uterus was enlarged to the size of a term pregnancy. No pelvic examination was done. The extremities were markedly edematous and the reflexes were hyperactive. The diagnosis was severe toxemia of pregnancy with evidence of increased intracranial pressure.

She received an infusion of 1000 cc of 10 percent dextrose in water and 10 mg of Compazine intramuscularly. She complained of severe headache. She was having no uterine contractions, but there was a small amount of bloody vaginal discharge. She vomited, and received Phenergan 25 mg and Demerol 100 mg for pain at 10:25 a.m.

She ate some soup and jello that evening; 15 minutes later she vomited. Her respirations were labored, and her extremities were rigid. The blood pressure was now 218/160. An injection of 2 cc of 50 percent M_gSO_4 was ordered. She then exhibited a grand mal seizure lasting 1-2 minutes. Her physician inserted an airway, and a Foley catheter was placed in the bladder. The blood pressure was 156/120. She was placed in an oxygen tent and received Serpasil 1 1/2 cc, and Thiomer in 2 cc. At 8 p.m. she had another convulsion. She was given Na Amytal 3 3/4 gr intravenously, 50 cc Mannitol, Aminophylin 25 mg and 2 g Na Phenobarbitol, but remaining unresponsive. Her temperature rose to 104.8°F and she died at 12:15 a.m. on February 20, 1967. The cause of death was thought to be cerebral hemorrage secondary to toxemia of pregnancy. There was no autopsy.

Comments

The Committee classified this case as a direct obstetric death with preventable factors on the part of both patient and physician. The patient was at fault in not keeping her appointment immediately after the appearance of the warning symptoms of impending eclampsia. The treatment for the convulsive toxemia was insufficiently vigorous for a patient as desperately ill as this one. Toxemia remains one of the major obstetric killers, and its management is a constant problem and challenge for the physician.

vacation in a vial: the spasm reactors in your practice deserve



"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

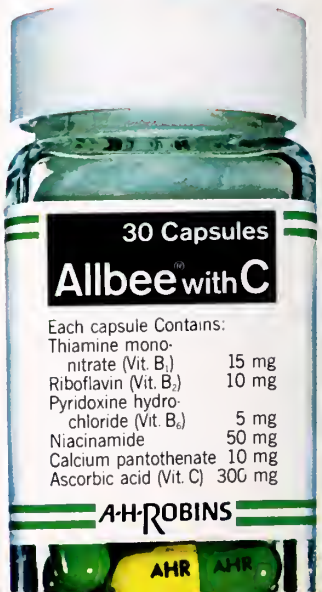
A·H·ROBINS

Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A. H. Robins Company, Richmond, Va. 23220



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M may be better to start on and easier to stay on.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-93-4C

Eightieth Annual Meeting

of the

MID-SOUTH MEDICAL ASSOCIATION

(Formerly Mid-South Postgraduate Medical Assembly)

MAY 21, 22, 23, 1969

at the

HOLIDAY-INN RIVERMONT • MEMPHIS, TENNESSEE

Outstanding speakers will present half-hour lectures on subjects of interest to both general practitioner and specialist. A well balanced program is scheduled. Make your plans to attend NOW!!

CLASS REUNIONS: Class of 1924; Class of 1929; Class of 1934 - June; Class of 1938 - December; Class of 1939 - March, June, December; Class of 1944 - March, June, September, December; Class of 1949 - March, June, September, December; Class of 1954 - March, June, September, December; Class of 1959 - March, June, September, December; Class of 1963 - December.

MAKE YOUR PLANS NOW TO ATTEND THE

MID-SOUTH MEDICAL ASSOCIATION

MAY 21, 22, 23, 1969

MEMPHIS TENNESSEE



INFECTION CONTROL IN THE HOSPITAL (Paper): Published by the American Hospital Association, Chicago, 1968; 140 Pages; Price $3.75.

This is a small manual compiled by experts in control of infections in hospitals. There is no specific author.

This book differs from the previous publication of the A.H.A. in that its 1962 edition had an English editor, whereas, this edition has an American coordinator and all American committee members who worked with him.

It covers all areas of the hospital environment—medical, technical and environmental, as well as the effect of hospital infections spreading to the community.

Its recommended use by the reviewer is for members of the Infection Control Committee in each hospital. By reading this manual, they can have a brief but complete picture of all that is involved in modern-day hospital infection control.

G. Dudley Nelson, M.D., M.P.H.

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES (Fourth Edition): by Charles Varga, M.D.; Published by The C. V. Mosby Company, St. Louis, 1968; 694 Pages; Price $19.75.

The fourth edition of this volume has several major changes over the previous edition. Ten of the 18 chapters have been entirely rewritten, most of them by contributors new to this edition.

Chapters are devoted to cardiovascular, neurologic, psychiatric, respiratory, endocrine, hematologic, newborn, ophthalmologic, genitourinary and metabolic emergencies and to emergencies related to pediatric anesthesia, hypersensitization and toxins, physical and chemical agents, and poisoning. Some 72 pages are devoted to description of pediatric procedures commonly used in pediatric practice. A new section on inhalation therapy has been added.

References are generally well selected and up-to-date.

The format varies from chapter to chapter but generally is in outline form. Cross references are used freely.

A reviewer can find fault with any book devoted to such a broad subject as therapy and management and bring out differences of opinion and omissions. For example, I would not agree with the recommendation of the three drugs, ampicillin, penicillin and sulfisoxazole, for acute bacterial meningitis pending identification of the specific organism. It would also seem that heparin therapy for shock with Gram negative sepsis or meningococcemia is sufficiently accepted to have been included. It must be conceded, however, that generally the methods of management recommended are excellent and little has been omitted.

This is a volume the practitioner will find quite helpful.

Walter T. Hughes, M.D.

PAEDIATRIC CARDIOLOGY: edited by Hamish Watson, M.D.; Published by The C. V. Mosby Company, St. Louis, 1968; 996 Pages; Price $36.50.

The above publication is a departure from the books on pediatric cardiology written by one author or joint authors from the same institution. Thirty-nine authorities on different aspects of the subject, from both sides of the Atlantic, have cooperated in this generally excellent 996 page volume divided into 68 appropriate chapters. The chapters retain the distinct individuality of the author, which is refreshing. The many illustrations are exceptionally good having been taken directly from the originals save when necessary like the ones in the chapters on Embryology and Surgical Aspects of Pediatric Cardiology.

The first 10 chapters are devoted to basic concepts and those on Foetal Circulation and Pulmonary Circulation in Pathological States are outstanding. The origin of mid-systolic clicks is left in doubt. It has now been conclusively proven that they originate from the deformed posterior leaflet of the mitral valve. Perhaps the importance of upright T waves in V_1 after the first week of life representing pressure overload of the right ventricle has not received the emphasis it deserves. It seems very regrettable to this reviewer that the very important subject of cardiac catheterization and angiocardiography is disposed of in less than two pages.

The description of individual anatomic entities carries with it a perspective of depth. The incidence, pathologic anatomy, the pathophysiology, criteria for diagnosis, clinical and instrumental, the prognosis and present status of corrective surgery are uniformly well handled. Chapters on Fallot's Tetralogy and Transposition of Great Vessels are particularly remarkable.

Medical Management of congestive heart failure in infants and children is well presented. For digitalization, digoxin is the drug of choice; the other alternative preparations listed being used very rarely. The last chapter on surgical aspects of Pediatric Cardiology is concise and to the point.

Kareem Minhas, M.D.

DOCTOR!

YOU ARE INVITED TO ATTEND

the

ANNUAL SPRING SCIENTIFIC SESSION

of the

KENTUCKY THORACIC SOCIETY

THURSDAY, APRIL 24

MID-TOWN HOLIDAY INN—LOUISVILLE, KENTUCKY

Morning Session

9:00 - 10:15 a.m. **RESPIRATORY DISEASE SCREENING—IS IT NECESSARY?**
A. H. Russakoff, M.D.
Internal Medicine
Birmingham, Alabama

Reactor Panel:
William H. Anderson, M.D., Louisville
George Brockman, M.D., Greenville
Richard B. McElvein, M.D., Lexington
Edward N. Maxwell, M.D., Louisville
D. Boyd Bigelow, M.D., Denver

10:30 - 11:45 a.m. **"Experience With Quantitative Cultures"**
Warren E. Wheeler, M.D., Professor and Chairman
Department of Pediatrics
University of Kentucky

12:00 noon **Luncheon**
"What's In The Air"
William H. Megonnell, Assistant Commissioner
Standards and Compliance
National Air Pollution Control Administration
Arlington, Virginia

2:00 - 2:30 p.m. **"Atypical Tuberculosis"**
H. M. Vandiviere, M.D., Professor
Department of Community Medicine
University of Kentucky

2:30 - 3:00 p.m. **"Pulmonary Complications of Congenital Heart Disease"**
Linda Walters, M.D., Assistant Professor
Department of Pediatrics
University of Kentucky

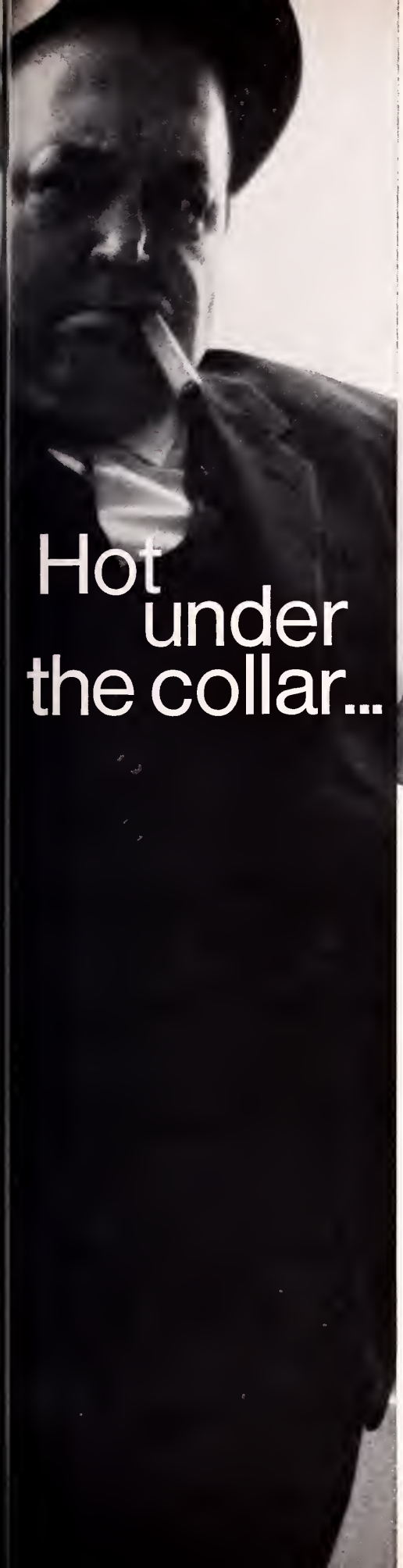
3:10 - 3:40 p.m. **"Mediastinoscopy"**
J. Kent Trinkle, M.D., Assistant Professor Of Surgery
University of Kentucky

3:50 - 4:20 p.m. **"Trachea-Bronchial and Esophageal Foreign Body Extraction"**
E. Nighbert, M.D., Resident in Surgery
University of Kentucky

4:30 - 5:00 p.m. **"Pulmonary Empolisation Following Pneumonectomy"**
W. Dooling, M.D.
VA Hospital, Lexington and Associate Professor of Surgery
University of Kentucky

6:30 p.m. **Dinner**
"Why A National Lung Institute?"
Congressman Tim Lee Carter, M.D.

KENTUCKY THORACIC SOCIETY · 1954 ·



Hot under the collar...



high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392



118th Annual Convention
AMA
NEW YORK CITY
JULY 13-17, 1969

The magnetism and the grandeur that characterizes New York City will provide a superb setting for AMA's 118th Annual Convention in July. Plan to attend now and look forward to five memorable and stimulating convention days in a city of unlimited excitement.

Continue your postgraduate education with a varied program of • four General Scientific Meetings on Chronic Pulmonary Insufficiency and Problems of Air Pollution, Human Sexuality, Impact of Medical Education on Patient Care, and Physical Fitness and Aging • 23 Section Programs • Color Television • Medical Motion Pictures • and over 700 scientific and industrial exhibits. The nation's outstanding medical authorities will lecture and discuss the significant advances in today's medicine.

In addition the AMA TV network will present more than 40 hours of convention programming.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, July 16, 1969. Since space is limited, we suggest you make your reservations before June 30, 1969. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 26, 1969.

NEW YORK CITY, NEW YORK • JULY 13-17, 1969
AMERICAN MEDICAL ASSOCIATION'S 118th ANNUAL CONVENTION

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

APRIL

18-19 Continuing Education Course, "Practical Exercises in Neurology, Neuro-surgery and Neuro-opthalmology," University of Kentucky College of Medicine, Lexington

21-24 Kentucky Hospital Association Annual Convention, Kentucky Hotel, Louisville

23 Respiratory Disease Conference, Seelbach Hotel, Louisville

24 Kentucky Thoracic Society Spring Scientific Session, Mid-Town Holiday Inn, Louisville

24 Kentucky TB and RD Association Annual Meeting, Mid-Town Holiday Inn, Louisville

24 Kentucky Psychiatric Association Spring Meeting, Imperial House, Lexington

25-26 Continuing Education Course, "A Seminar on Laboratory Management," University of Kentucky College of Medicine, Lexington

29-May 2 "Current Concepts in Bone and Joint Disease," Symposium, University of Kentucky Medical Center, Lexington

MAY

2-3 Continuing Education Course, "Cytopathology of Uterine Cancer", University of Kentucky College of Medicine, Lexington

6-10 Kentucky Academy of General Practice Annual Meeting, Convention Center and Seelbach Hotel, Louisville

12 Breast Cancer Symposium, University of Louisville School of Medicine, Louisville

13-15 Continuing Education Course, "Pneumoconioses," University of Kentucky College of Medicine, Lexington

14-15 Kentucky Chapter, American Academy of Pediatrics Annual Spring Meeting, Holiday Inn, Somerset

16-17 Kentucky Chapter, American College of Surgeons and Kentucky Surgical Society Joint Meeting, Holiday Inn, Somerset

16-18 Kentucky State Association of Medical Assistants Seventh Annual Convention, Holiday Inn, Elizabethtown

28-29 Continuing Education Course "Perinatal Symposium," University of Kentucky College of Medicine, Lexington

IN SURROUNDING STATES

APRIL

16-17 Postgraduate Course, "Symposium on Rheumatic Disease," Cleveland Clinic Educational Foundation, Cleveland, Ohio

16-19 Thirteenth Annual Postgraduate Course in Trauma, Chicago Committee on Trauma of the American College of Surgeons, John B. Murphy Memorial Auditorium, Chicago, Ill.

20-26 International Symposium, Obstetrics and Gynecology, Chicago, Ill.

21-23 American Academy of Pediatrics Annual Spring Session, Sheraton-Boston Hotel, Boston, Mass.

24-26 American Academy of Physical Medicine and Rehabilitation 31st Annual Session, Sheraton-Chicago Hotel, Chicago, Ill.

26-27 Twenty-first Annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology, University of Cincinnati College of Medicine, Cincinnati, Ohio

28-May 1 Seventeenth Annual Clinical Meeting, American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla.

MAY

8-10 Postgraduate Course in Pediatrics, University of Cincinnati Department of Pediatrics, Cincinnati, Ohio

8-10 National Conference on Breast Cancer, Shoreham Hotel, Washington, D.C.

14-16 National Society for the Prevention of Blindness, Inc., Annual Conference, Pfister Hotel, Milwaukee, Wisconsin

21-23 Mid-South Medical Association, Holiday-Inn Rivermont, Memphis, Tennessee

his ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

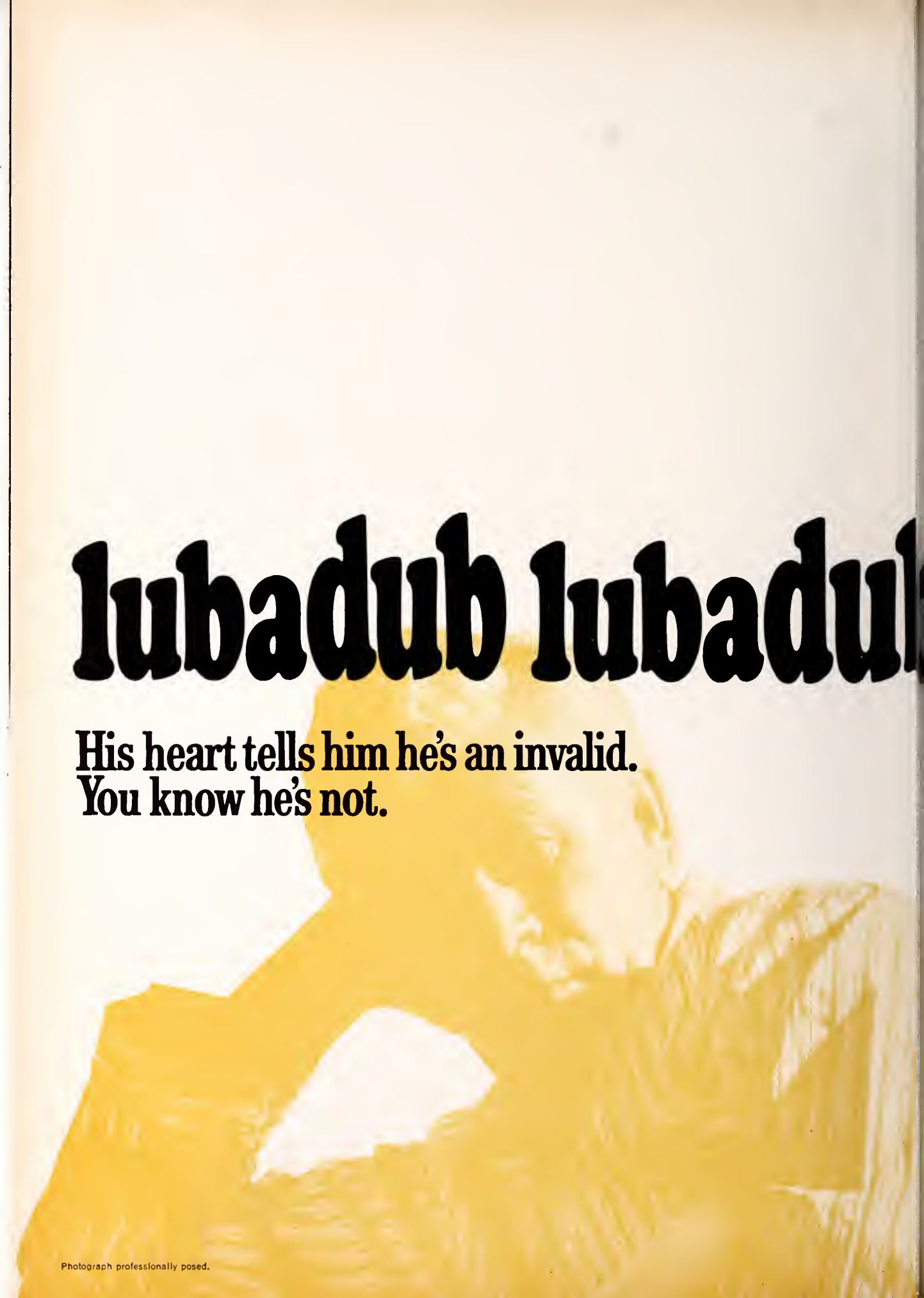
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ıbadubdub lubadı

ıxiety is expected in the cardiovascular patient.
little may even be desirable.

ıt when anxiety is exaggerated . . . when it
terferes with sleep . . . when it aggravates
.rdiovascular symptoms, your help may
: needed.

ıturally, you'll want to reassure the patient.

ıd perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
de effects are generally limited to transient
owsiness; serious, therapy-interrupting
de effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®


P
M
P
M

A little sunshine for summer cold and allergy sufferers.

histine LP can brighten things in
y for your summer cold and
y patients.
continuous-release, deconges-
ablets contain a vasoconstrictor-
stamine formulation that goes to
promptly and usually provides
ive relief even in those cases
al congestion caused by repeated
c episodes.
convenient twice-a-day dosage with Novahistine LP lets most patients enjoy relief all day and all night.
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

DOW

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1969 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 23, 24, 25**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

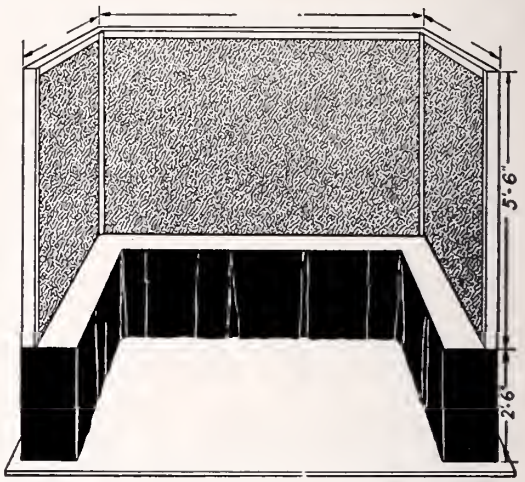
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1969

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)
 Institution (if desired):
 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
 Charts and Posters.... Photographs.... Drawings.... X-rays
 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
 Amount of total wall space needed?
 Back wall Side walls (All side walls are 4')
 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided to you in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

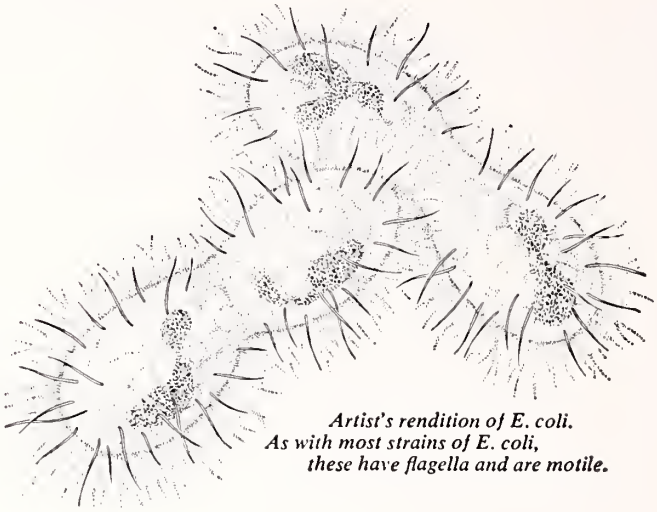
Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

To help avert chronicity in acute cystitis



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

Although it may coexist wi
chronic pyelonephritis or prost
titis, many cases of chronic cys
tis may result from incomple
treatment of a simple, acute cys
tis. For this reason, it is beir
increasingly recommended th
appropriate antibacterial therap
in full dosage be maintained f
up to two weeks or longer.

Most frequently, the dominar
pathogen is gram-negative, us
ally *E. coli;* most often, you wi
find Gantanol® (sulfametho
azole) effective against *E. co*
and other sensitive organisms
gram-positive and gram-negativ
—commonly seen in cystitis an
other urinary tract infection
Wide clinical usage of Gantan
has confirmed the efficacy of th
wide-spectrum antimicrobi
agent in the treatment of cystiti

The rapidity of bacterial mu
tiplication in a favorable urinar
environment is well know
Prompt control of acute bladd
infection is therefore essenti

Before prescribing, please consult cor
plete product information, a summary
which follows:

Indications: Acute and chronic urina
tract, respiratory and soft tissue infe
tions due to susceptible microorganism
prophylactically following diagnostic i
strumental procedures on genitourina
tract.

Contraindicated in sulfonamide-sensiti
patients, pregnant females at term, pr
mature infants, or newborn infants du
ing first 3 months of life.

Warnings: Use only after critical a
praisal in patients with liver or ren
damage, urinary obstruction or bloc
dyscrasias. Deaths reported from h
persensitivity reactions, Stevens-Johns
syndrome, agranulocytosis, aplastic an
mia and other blood dyscrasias. In close
intermittent or prolonged therapy, bloc
counts and liver and kidney function tes
should be performed. Clinical data insu
ficient on prolonged or recurrent therap
in chronic renal diseases of children u
der 6 years.

Precautions: Occasional failures may o
cur due to resistant microorganisms. N
effective in virus and rickettsial infe
tions. Sulfonamides not recommend

ot only to reduce the patient's iscomfort but to prevent chron-ity and possible ascending in-ection.

Gantanol (sulfamethoxazole) rovides antibacterial activity ithin two hours of the initial 2-m dose, and subsequent 1-Gm oses, taken morning and eve-ing, maintain therapeutic blood nd urine levels lasting up to 12 ours. Significant symptomatic sponse is frequently achieved ithin 24 to 48 hours in acute, ncomplicated cystitis and other sponsive urinary tract infec-ons. In addition, Gantanol is sually well tolerated. Should olonged therapy be required, ie convenient *b.i.d.* dosage helps minimize the problem of ipped doses.

Over eight years' clinical use as thoroughly demonstrated the ualities that make Gantanol a od choice for initial therapy of ost urinary tract infections, in-uding acute cystitis.

r therapy of acute infections caused by oup A beta-hemolytic streptococci. At esent, penicillin is drug of choice in ute group A beta-hemolytic streptococ-l infections; although Gantanol has oduced favorable bacteriologic conver-n rates in this infection, data insuffi-nt on long-term follow-up studies as to effect on sequelae of rheumatic fever acute glomerulonephritis. If other atment cannot be used and Gantanol employed in such infections, *important it therapy be continued in usual rec-mended dosage for at least 10 days.* serve usual sulfonamide therapy pre-utions, including adequate fluid intake. e with caution if history of allergies d/or asthma. Follow closely patients h renal impairment since this may se excessive drug accumulation. Need indicated local measures or surgery t obviated in localized infections.

verse Reactions: Depending upon the erity of the reaction, may withdraw g in event of headache, nausea, vomit-, urticaria, diarrhea, hepatitis, pancre-tis, blood dyscrasias, neuropathy, drug er, Stevens-Johnson syndrome, skin h, injection of the conjunctiva and era, petechiae, purpura, hematuria and stalluria.

Gantanol® (sulfamethoxazole) assures rapid, sustained, antibacterial activity with b.i.d. dosage

Gantanol® B.I.D. (sulfamethoxazole)

ROCHE
Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

WHAT'S NEW

in

Medical Progress

An Approach to the Prevention of Coronary Artery Disease†

CHARLES H. DUNCAN, M.D. and MAURICE M. BEST, M.D.

IT is clear that the most effective approach to reducing the toll from coronary artery disease is the application of preventive measures prior to the onset of clinically recognizable heart disease. We have recently reviewed the more important factors responsible for the development of premature atherosclerosis of the coronary circulation and proposed a coronary score card by which the susceptible individual can be recognized.[1]

Major coronary risk factors which are susceptible to modification include:

Elevated blood cholesterol and/or triglyceride
Hypertension
Decreased carbohydrate tolerance
Cigarette smoking
Obesity
Sedentary habits

The presence of any one of these risk factors results in an increased risk, but it is the additive effect of multiple factors which dramatically increases the hazard of coronary disease. Thus Stamler's data indicate that either cigarette smoking or elevated serum cholesterol (above 225 mg/100 ml) increases by five times the risk of coronary heart disease, while the combination of cigarette smoking and elevated cholesterol results in a risk 12 times that of the non-smoker with normal cholesterol.[2]

Much admittedly remains to be learned about measures for the primary prevention of coronary disease and their effectiveness, but it seems certain that currently available measures can greatly reduce the incidence of this disease in the American male. The earlier in life preventive measures are adopted the more effective they should be in delaying or preventing coronary disease. Since many of the predisposing factors (elevated blood lipids, hypertension, obesity, decreased carbohydrate tolerance) tend to be familial, relatives of the patient with premature coronary disease should be screened and appropriate preventive measures instituted.

Preventive measures to reduce or eliminate the additional risk attributable to cigarette smoking, obesity and sedentary habits are self evident. That is not to say that they are easily achieved, and the modification of long-standing habits will tax the skill and patience of the best of physicians.

With presently available drugs hypertension can be controlled in the majority of patients. Since the relationship between blood pressure and coronary disease is a continuum, the goal of treatment should be the maintenance of normal blood pressure. The choice of antihypertensive agents is initially empirical, but the physician must not hesitate to experiment with dosage and drugs in his effort to maintain normal blood pressure.

Recent knowledge permits a much more logical approach to the management of elevated blood lipids than was possible several years ago. There can be little doubt that the usual American diet is an important factor in the commonly encountered elevations of blood cholesterol and triglyceride.[3] Elevated levels of blood cholesterol can be reduced by changes in diet which provide for a reduced cholesterol intake and the substitution of polyunsaturated vegetable fats for a large part of the saturated animal fat content. A useful booklet for the planning of such fat-controlled meals is available on prescription without cost to patients from local chapters of the American Heart Association.

The correction of elevated levels of triglyceride may also be approached by dietary means. With rare exception the elevation of triglyceride encountered in adults is of the "carbohydrate induced" type. A reduced intake of carbohydrate will in most cases result in a reduction of serum triglyceride, particularly if it is accompanied by some reduction in weight. Evidence suggests that remaining dietary carbohydrate should be predominantly in the form of starch or other complex carbohydrate rather than simple sugars.

At least some hypertriglyceridemic patients demonstrate marked exacerbations of their hyperlipemia in response to alcohol, and this possibility should be kept in mind, particularly when triglyceride levels fluctuate markedly.

†*From the department of medicine, University of Louisville School of Medicine*

This research was supported in part by PHS Grant HE-01946 and by grants from the Kentucky Heart Association and the Heart Association of Louisville and Jefferson County. We are grateful to Ayerst Laboratories, Flint Laboratories, Eli Lilly & Company and USV Pharmaceutical Corporation for assistance.

Although dietary modification is an essential first step in the management of the patient with hyperlipidemia, often serum lipids are not reduced to the desired level and a lipid lowering drug must be combined with the change in diet. Currently four agents combine effectiveness with a low incidence of serious or unpleasant side effects. In our laboratory we are now using clofibrate, phenformin hydrochloride, dextrothyroxine, and cholestyramine. The choice of a particular agent is based upon the lipid profile of the patient, and since therapy may be continued throughout life, considerations of safety and convenience are important.

In patients with elevated triglyceride, with or without elevated cholesterol levels, clofibrate is the drug of first choice. It substantially reduces triglyceride and to a lesser degree cholesterol in the majority of such patients.[4] The more convenient dosage schedule of 1 gram twice daily seems to be fully as effective as the recommended 0.5 grams four times daily. Clofibrate is less predictably effective in patients with normal triglyceride and elevated cholesterol levels, particularly those with the very high levels encountered in familial hypercholesterolemia.

An important precaution to observe in the use of clofibrate stems from its potentiation of the effects of the warfarin anticoagulants; the maintenance dose of anticoagulant should be reduced by about one third when clofibrate treatment is started, and prothrombin time followed closely until the new maintenance dose of anticoagulant is established.

We advise that all patients with elevated fasting triglyceride levels have a standard three-hour glucose tolerance test, since a considerable number will be found to have borderline or clearly abnormal results. In those patients with impaired carbohydrate tolerance the use of the oral antidiabetic drug phenformin in conjunction with diet will result in both improved carbohydrate tolerance and a reduction of triglyceride and cholesterol levels.[5] Usually 50 mg. taken with breakfast is sufficient, but a second 50 mg. may be taken with the evening meal.

If normal glucose tolerance is not restored by this regimen, it should be supplemented with a sulfonylurea such as acetohexamide.[6] If the patient remains hyperlipidemic, clofibrate in the usual dose should be added.

In those patients with elevations in cholesterol but little or no triglyceride abnormality who do not respond to clofibrate, two additional drugs warrant consideration.

Dextrothyroxine is moderately effective in reducing elevated levels of serum cholesterol but has little effect on triglyceride. In view of its thyromimetic activity, the principal use of dextrothyroxine is in the primary prevention of coronary artery disease and it must be used with caution in patients with angina pectoris or previous myocardial infarction. Treatment should be initiated with 2 mg. and increased stepwise to a maximum single daily dose of 6 to 8 mg. In our experience, dextrothyroxine and clofibrate have an additive effect in reducing serum cholesterol and the two drugs may be used together.[7] As with clofibrate, some reduction in oral anticoagulant dose may be necessary when dextrothyroxine therapy is undertaken.

In the patient with familial hypercholesterolemia and cholesterol levels exceeding 400 mg/100 ml, normal levels of cholesterol can rarely if ever be achieved with diet and the above mentioned drugs. Since this particular disorder conveys a high risk of early death from myocardial infarction, one should consider the use of the bile acid binding resin, cholestyramine.

The only currently recommended use for cholestyramine is for relief of pruritus due to partial biliary obstruction, and its use to lower serum cholesterol is still in the experimental stage.[8] We have, however, confirmed the reports of its effectiveness for this latter purpose, although the dose required to reduce cholesterol is usually somewhat greater than the 12 grams daily that has been recommended in biliary disease.

To summarize the approach to the management of hyperlipidemia (cholesterol above 220 or triglyceride above 150 mg/100 ml), it is recommended that:

1) At least three pretreatment determinations of plasma cholesterol and triglyceride following an overnight fast should be obtained to define the nature and degree of lipid abnormality.

2) If triglyceride is elevated, a standard glucose tolerance test should be performed.

3) The initial step in management should be dietary, including:

a) Weight reduction if indicated.

b) For hypercholesterolemia, restriction of cholesterol, or both.

c) For hypertriglyceridemia, restriction of carbohydrate, especially sugars.

4) If normal levels of plasma lipids are not achieved by dietary measures, one or more of the following drugs should be added to the dietary regimen:

a) Clofibrate (Atromid-S); 2 grams daily in divided doses for elevations of triglyceride, cholesterol, or both.

b) Dextrothyroxine (Choloxin); 2 mg. stepwise increase in dose to maximum of 6 to 8 mg. daily for elevation of cholesterol alone. May be used together with Clofibrate.

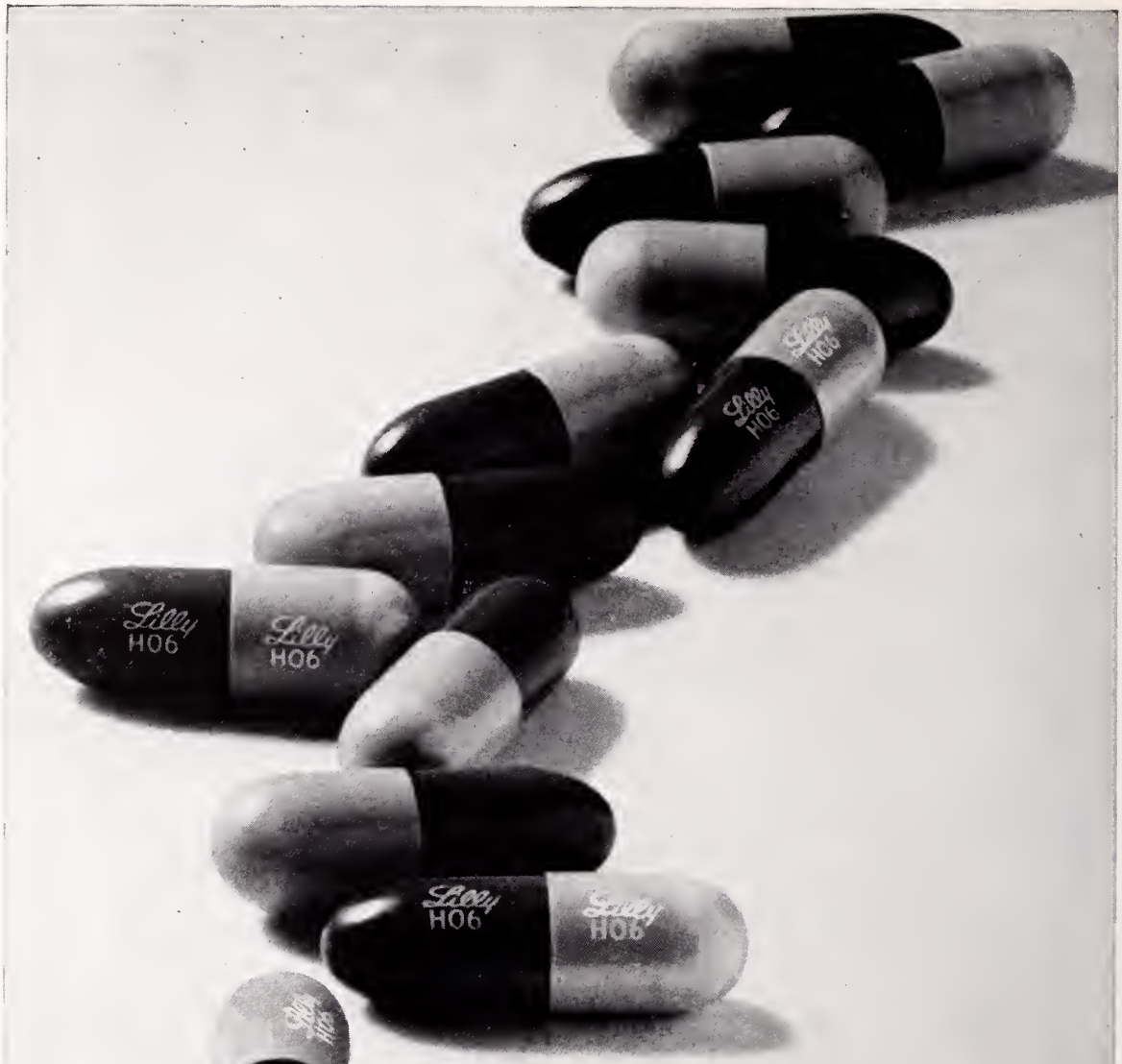
c) Phenformin (DBI-TD); 50 mg. one or two times daily, supplemented if necessary with acetohexamide (Dymelor) 250 to 500 mg. daily, in patients with abnormal glucose tolerance.

d) Cholestyramine (Questran); 12 to 24 grams daily in divided doses before meals is promising but still experimental, and its use should be limited to those patients with the extreme elevations of cholesterol found in familial hypercholesterolemia.

References

1. Duncan C.H. and Best, M.M.: Management of the coronary-prone patient. *GP* 35: 119-127, 1967.

(Continued on page 309)



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 APRIL, 1969 No. 4

Reye's Syndrome: An Association with Influenza A Infection†

BRYAN D. HALL, M.D.*, WALTER T. HUGHES, JR., M.D.**
and DONALD KMETZ, M.D.***

Louisville, Kentucky

The etiology of Reye's Syndrome is presently unknown. A case is reported herein with an associated rising titer to influenza A virus. In these cases where a virus has been incriminated it appears to be the host susceptability and not the specific virus which permits an otherwise benign infection to progress to the usually fatal syndrome.

IN 1929 Turnbull[1] described the case of a three-year-old boy with fatty infiltration of the liver and encephalopathy. Hill, *et al*,[2] in 1955 noted similar findings in West Indian children who died of a "vomiting-sickness" after ingestion of the akee nut. Thereafter, a few sporadic reports appeared describing similar abnormalities.[3-7] In 1963, Reye and associates reported 21 cases of a rapidly fatal disease characterized by severe vomiting, disturbed consciousness, seizures, hypoglycemia, cerebral edema, and fatty degeneration of the liver and kidney. Several reports followed comparable enough to label the entity Reye's Syndrome.[9-27]

At present, approximately 122 cases of Reye's Syndrome have been reported, but no specific etiology has been delineated. A case is presented of a child with an associated influenza A infection. It is suggested that the influenza A virus was the etiology of the disease and that viruses play a significant role in the pathogenesis of Reye's Syndrome.

Report of a Case

A 13-year-old white female, previously in good health, developed nasal congestion and cough five days prior to admission. The next day she became febrile and a day later began severe vomiting. Two days prior to admission she was lethargic and complained of generalized myalgia. Vomiting persisted, and she became comatose on the day of admission to Louisville Children's Hospital.

There had been no known contact with toxic materials; however, an influenza-like illness had been prevalent in her neighborhood. A sibling had a "cold" at the time, and the parents knew of a member of a family 40 miles away who had an illness similar to the patient's. Both families had horses ill with rhinorrhea and weak legs on the premises. The history was otherwise non-remarkable.

Physical examination revealed on unconscious girl who was unresponsive to stimuli.

†*From the departments of pediatrics and pathology, University of Louisville School of Medicine, Louisville, Kentucky. Reprint requests to Captain Bryan D. Hall, FV 3186709, David Grant USAF Hospital, (Pediatrics), Travis AFB, California* 94535
**Chief resident, Children's Hospital, Louisville*
***Professor and acting chairman, department of pediatrics*
****Director of Laboratories, Children's Hospital*

She was well-nourished and well-developed. The temperature was 100.6° F (Rectal); blood pressure, 190/100 mm.Hg.; respiratory rate, 30 per minute; and the pulse rate was 100 per minute. The pertinent physical abnormalities were slight blurring of the optic discs, hypoactive deep tendon reflexes, and bilateral Babinski responses. There was no organomegaly or exanthem.

Laboratory data on admission included hemoglobin, 15.5 gms/100 ml; hematocrit, 46 vol.%; blood glucose, 106 mg/100 ml; blood urea nitrogen, 17 mg/100 ml; serum sodium, 146 mEq/L; serum chloride, 108 mEq/L; serum potassium, 4.7 mEq/L; and CO_2 content, 25.4 mm/L. The white blood cell count was 17,500/cu.mm with 60% neutrophils and 40% lymphocytes. There was a trace of acetone in an otherwise normal urine. Roentgenograms of the chest, abdomen and skull were unremarkable. The cerebrospinal fluid was normal except for an opening pressure of 400 mm H_2O and a closing pressure of 170 mm H_2O.

An electroencephalogram one day following admission revealed a generalized slow wave pattern compatible with a diffuse encephalopathy. Bacterial cultures of the nose, throat, urine, and blood were not remarkable. Viral cultures were not obtained from the stools or pharynx, but those from the spinal fluid were negative for influenza, parainfluenza, and the neurotropic viruses. On the day of admission complement-fixation titers for influenza A and B were 1:8; however, three days later the influenza A titer rose to 1:128 without any change in the influenza B titer.

Despite intensive therapy with intravenous fluids, anti-convulsants (Sodium Amytal, Dilantin), hypothermic blankets, antihypertensive agents (Reserpine), steroids (Decadron, Solucortef), antibiotics (Ampicillin), and assisted respiration via tracheal intubation, the patient progressively worsened. By the second hospital day she was oliguric and vomited coffee-ground material. The following day shock ensued and she died.

Postmortem findings revealed 60 ml. of bloody fluid in the right pleural space which communicated with a linear perforated stress ulcer of the distal esophagus. Except for some congestion and hemorrhage, the lungs were normal. The peritoneal cavity contained a small amount of clotted blood probably originating from a perforated ulceration of the anterior wall of the duodenum. The liver was not heavy, but it had a dark yellow-orange appearance. Microscopically, there was a diffuse fatty metamorphosis of the liver which was most prominent in the central zone. There were focal areas of hepatic necrosis with a mild focal polymorphonuclear response. Numerous large red intranuclear inclusions were present in the hepatic cells. The kidneys were slightly enlarged and the surface showed scattered geographic areas of pale discoloration which extended irregularly into the cortex. Microscopic sections revealed focal cortical necrosis with generalized swelling and granular degeneration of the proximal renal tubules. The brain was edematous and there was mild uncal herniation. Sections revealed focal white matter degeneration, but no evidence of meningeal inflammation or perivascular infiltration. Examination showed the rest of the organs to be normal except for a diffusely autolyzed pancreas.

Comment

The increase in the influenza A antibody titer from 1:8 on the day of admission to 1:128 three days later is indicative of active influenza A infection. The combination of prominent intranuclear inclusions with focal hepatic and renal necrosis suggests a generalized viremia with a direct effect on these organs. Since no evidence of a viral infection was noted within the central nervous system, it seems likely that the primary disease was not the encephalopathy.

That influenza viruses are a specific cause of Reye's Syndrome is quite unlikely since similar pathological changes are not usually encountered in influenza epidemics.[28,29] The influenza A virus did appear to play a role in the pathogenesis of our patient's illness. Other authors have noted, but have not substantiated the possibility of the influenza viruses causing Reye's Syndrome. [5,12,17,25,26] One report demonstrated a high titer to parainfluenza 3.[26]

Seven cases of Reye's Syndrome have occurred with concurrent chickenpox infection. [3,4,18,20,27] Other cases have been associated with

the isolation of Echo, type 11[15], Echo, type 8[19], Coxsackie A-9[26], Coxsackie B-1[26], Coxsackie B-4[19], Reovirus[6,11], Adenovirus[12], and herpes simplex.[16]

In the case reported by Randolph and Gelfman[30] viral cultures and serological studies were made of the patient as well as his parents and siblings. No viruses were isolated and complement-fixation tests for mumps, herpes simplex, influenza type A & B, adenovirus group, parainfluenza and respiratory syncytial virus did not reflect infection. This patient recovered and histologic examination of the liver was not accomplished.

The development of Reye's Syndrome in children with varicella, influenza, and other viral agents seems to depend upon some host susceptibility and not specifically to the virus. This is likely the case since many of these infections occur without Reye's Syndrome. More thorough viral studies on patients presented with the symptom complex of Reye's Syndrome will greatly clarify the viral etiology of the syndrome.

Summary

A case of Reye's Syndrome is presented in which a rising titer to influenza A was demonstrated. It is concluded that the influenza A infection played a role in the pathogenesis of the illness, but that it is not a specific cause of the syndrome. Host susceptibility may determine which child develops this infrequent complication among those with a variety of common viral infections.

References

1. Brain, W. Russell, Hunter, Donald, and Turnbull, Hubert M.: Acute Meningo-encephalomyelitis of Childhood. Report of Six Cases. *Lancet* 1:221-227, February 2, 1929.
2. Hill, K. R., Bras, G., and Clearkin, K. P.: Acute Toxic Hypoglycemia Occuring in the Vomiting Sickness of Jamaica; Morbid Anatomical Aspects. *W. Indian Med. J.* 4:91-104, June, 1955.
3. Wright, Elmer M., Lipson, Martha J., and Mortimer, Edward A.: Varicella and Severe Hypoglycemia (Society Transactions). *Amer. J. Dis. Child.*, 92:512, November, 1956.
4. Mortimer, Edward A., Jr. and Lepow, Martha Lipson: Varicella with hypoglycemia possibly due to salicylates. *Amer. J. Dis. Child.* 103:583-590, April, 1962.
5. Anderson, R. McD.: Encephalitis in Childhood: Pathological Aspects. *M.J. Aust* 1:573-575, April 20, 1963.
6. Bourne, W.A.: Liver Disease of Infancy, Clinicopathological Conference. *Postgrad. Med. J.* 38:642, November, 1962.
7. Curry, A. S., Guttman, Helene A. Nathan, and Price, D. E.: A urinary Pteridine in a case of liver failure. *Lancet* 1:885-886, April 28, 1962.
8. Reye, R.D.K., Morgan, Graeme, and Baral, J.: Encephalopathy and fatty degeneration of the Viscera. A disease entity of childhood. *Lancet* 11:749, 1963.
9. Corlett, Keitha: (Letters to The Editor). Encephalopathy and Fatty Degeneration of the Viscera. *Lancet* 11:937, November 2, 1963.
10. Utian, H. L., Wagner, J.M., and Sichel, R.J.S.: "White Liver" disease. *Lancet* 11:1043, November 14, 1964.
11. Randolph, Martin, Kranwinkel, Ramon, Johnson, Ronald and Gelfman, Nelson A.: Encephalopathy, hepatitis, and fat accumulation in Viscera. *Amer. J. Dis. Child.* 110:95-99, July, 1965.
12. Dvorackova, I., Vortel, V., Hroch, M., and Kralove, Hradec: Encephalitic syndrome with fatty infiltration of viscera, *Arch. Path.* 81:240-246, March, 1966.
13. Jabbour, J. T., Howard, Paxton, H., and Jaques, William E.: Encephalopathy and fatty degeneration of the liver and kidneys. *JAMA* 194:1245-1247, December 13, 1965.
14. Winograd, Herbert L.: Encephalopathy with hypoglycemia and degeneration of the liver. *JAMA* 194:1247, December 13, 1965.
15. Golden, Gerald S., and Duffell, David: Encephalopathy and fatty change in the liver and kidney. *Pediatrics* 30:67-74, July, 1965.
16. Becroft, D.M.O.: Syndrome of encephalopathy and fatty degeneration of viscera in New Zealand children. *BMJ* 2:135-140, July, 1966.
17. Simpson, Hamish: Encephalopathy and fatty degeneration of the viscera: acid-base observations. *Lancet* 11:1274-1277, December 11, 1966.
18. Case Records of the Massachusetts General Hospital: (Discussant, Dr. Sidney Gellis). *NEJM* 276:47-55, January 5, 1967.
19. Johnson, George Magnus, Scurletis, Theodore D., and Carroll, Norma B.: A study of sixteen fatal cases of encephalitis-like disease in North Carolina children. *N. Carolina Med. J.* 24:464-473, October, 1963.
20. Jenkins, Ramon, Dvorak, Ann, and Patrick, James: Encephalopathy and fatty degeneration of the viscera associated with chickenpox. *Pediatrics* 39:769-771, May, 1967.
21. Glasgow, John F.T. and Ferris, J.A.J.: Encephalopathy and visceral fatty infiltration of probable toxic aetiology. *Lancet* 11: 451-453, March 2, 1968.
22. Joske, R.A, Keall, D.D., Leak, P.J., Stanley, N.F., and Walters, M.N.I.: Hepatitis-encephalitis in humans with reovirus infection. *Arch. Intern. Med.* 113:811, 1964.
23. Stejskal, J. and Kluska, Vladimir: Encephalopathy and fatty degeneration of the viscera. *Lancet* 1:615, March 14, 1964.
24. Bradford, William D. and Latham, William C.: Acute encephalopathy and fatty hepatomegaly. *Amer. J. Dis. Child.* 114: 152-156, August, 1967.
25. Schwartz, Allen D., Huttenlocher, Peter R., and Klatskin, Gerald: Abstract From The Seventy-Eighth Annual Meeting of The American Pediatric Society in Atlantic City, New Jersey: *Hepatic failure in 8 cases of Reye's Syndrome*, p., 20, 1968.
26. Barr, Robin, Glass, Irving, H. J., and Chawla, Gurbachan, S.: Reye's Syndrome: Massive fatty metamorphosis of the liver with acute encephalopathy. *Canad. Med. Ass. J.* 98:1038-1044, June 1, 1968.
27. Abruzzi, William A.: Varicella Encephalitis. *New York J.M.* 61:3912, November 15, 1961.
28. Eickhoff, Theodore C., Sherman, Ida L., and Serfling, Robert E.: Observations on Excess Mortality Associated with Epidemic Influenza. *JAMA* 176:776-782, June 3, 1961.
29. Bashore, Sidney, M., Bosniak, Morton A., Akka, Rouben I., and Flanigan, William J.: Asian influenza: Review of 1,264 unselected cases. *U.S. Armed Forces Med. J.* 9:1569-1579, November, 1958.
30. Randolph, M. and Gelfman, N.A.: Acute Encephalopathy in Children Associated with Acute Hepatocellular Dysfunction. *Amer. J. Dis. Child.* 116:303-307, September, 1968.

Fibroplastic Endocarditis with Eosinophilia (Loeffler's Endocarditis)†

William C. Gaventa, M.D., Franklin G. Hoffman, M.D., F.A.C.P.
and Walter L. Broghamer, M.D.

Louisville, Kentucky

A rare form of progressive endocardiomyopathy which should be considered in the differential diagnosis of patients who have congestive heart failure and eosinophilia is reported and discussed.

In 1936 Loeffler first described two cases of endocardiomyopathy of unknown etiology but associated with eosinophilia.[1] This syndrome subsequently became known as parietal fibroplastic endocarditis with eosinophilia, or Loeffler's endocarditis. Its rarity is attested to by the fact that in 1963 only 40 such cases had been described, chiefly from Europe.[2] Three of these were reported in American literature, the first of them in 1955 by Hoffman, Rosenbaum, and Genovese.[3] Since 1963 nine more single case reports have appeared in European literature. Mautner and Harris in Canada described one patient in 1966[4] making a total of four cases in North America, and 50 in the world literature.

The cardiac changes in this syndrome have been rather uniform in all reports. The pericardium, coronary arteries, and valves are essentially normal. The myocardium is hypertrophied and shows scattered areas of fibrosis and inflammatory infiltrates, sometimes containing eosinophils. The endocardial changes are the most striking. The parietal endocardium of either or both ventricles is greatly thickened and fibrotic, and the papillary muscles and chordae tendineae are sometimes involved, producing mitral or tricuspid insufficiency. Mural thrombi are frequent, as well as embolic complications. These endocardial changes associated with eosinophilic leukocytosis are the essential diagnostic criteria.

In view of the unusual nature of this syndrome and the increased clinical interest in endomyocardial diseases as obscure causes of heart failure the following additional case is presented.

Case Report

A 33-year-old Negro male was admitted to the Louisville Veterans Administration Hospital on September 6, 1966 because of weakness, night sweats, and a 30 pound weight loss in the preceding 3 months. He also had productive cough, occasional hemoptysis, and paroxysmal dyspnea, but had worked until one week prior to admission.

On two previous admissions, because of bleeding duodenal ulcer in 1963 and 1964, he had been noted to have eosinophilia of 14 percent and 16 percent with normal total leukocyte counts, but chest X-rays, electrocardiograms and physical findings in the heart and lungs then were normal. There were no allergies or sensitivities and no history of parasitic diseases or drug ingestion. The family history was non-contributory. The patient had never been abroad except for Army service in Europe from 1953 to 1955, and he was employed as an assembly line worker in a manufacturing plant with no known exposure to toxic agents.

Physical examination revealed a thin, pale man appearing acutely ill. Temperature was 100.6 F., pulse, 126 and regular, and respirations, 36. Blood pressure was 100/60. The lungs were resonant with normal breath sounds and no rales. A high-pitched extracardiac systolic scratching sound was heard at the apex. A protodiastolic gallop not noted on admission was subsequently heard. Liver and spleen were both firm, non-tender, and

†*A case report and discussion from the department of medicine, Veterans Administration Hospital, and the University of Louisville School of Medicine*

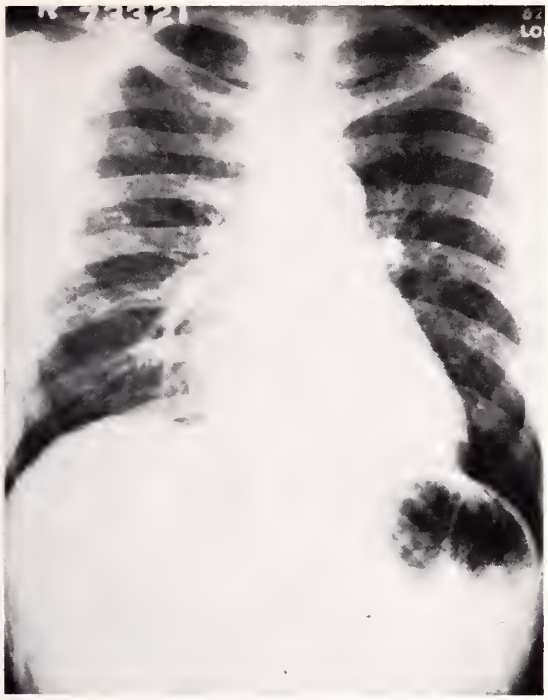


FIGURE 1. Chest film showing normal heart and lungs prior to present illness.



FIGURE 2. Chest film on present hospital admission showing cardiomegaly and pulmonary congestion.

palpable 4 cm below the costal margin. Small, discrete, firm lymph nodes were palpable in the neck, axillae, and inguinal regions.

Laboratory studies revealed one plus proteinuria, with small granular casts and very few white and red blood cells in the urinary sediment. Blood urea nitrogen was 72 mg/100 ml on admission, but subsequently fell to 28 mg/100 ml. Chest roentgenogram on admission revealed generalized cardiomegaly with fine fluffy densities suggestive of congestive failure, but these were improved on a subsequent film after two weeks. Electrocardiograms showed persistent sinus tachycardia, left axis deviation, poor R wave progression in the right precordial leads, and ST segment changes in leads V4 through V6 compatible with left ventricular hypertrophy.

Hematologic changes were the most striking features. The admission hemoglobin was 7.9 g/100 ml with hematocrit of 26%, white blood count was 65,750/mm^3 with 30% eosinophils, and platelets were reduced in the peripheral smears. Anemia persisted despite multiple transfusions. The white blood count increased to 129,000/mm^3 by September 12, 1966, but subsequently fell to 4,320 with eosinophils gradually decreasing to 8.5%. Platelet count was 17,000 on September 12, 1966, but eventually fell to 5,000/-mm^3 Bone marrow aspiration on September 7, 1966 was cellular, with a myeloid shift to the left, marked toxic granulation, and diminished megakaryocytes.

The patient remained acutely ill. He was febrile for the first 48 hours, then afebrile until the day of death when his temperature rose to 101 F. Tachycardia, dyspnea, and pallor persisted, together with profound weakness, intermittent chest pain, and occasional hemoptysis. There was slight clinical improvement at first, but then a progressive downhill course until September 27, 1966 when he became acutely dyspneic, began expectorating copious amounts of bright red frothy sputum, and expired.

Bacterial endocarditis, diffuse granulomatous disease, and acute leukemia were diagnostic considerations. Treatment consisted of digitalization, oxygen, diuretics, blood transfusions, antibiotics, and steroids, but to no avail. 6-Mercaptopurine, 150 mg per day, was given on September 10, 11, and 12, but then was discontinued when the hematology consultant concluded that the marrow was reactive, without evidence of leukemia. Anti-

biotics included penicillin, streptomycin, and chloramphenicol, the latter being administered from September 14 to September 26.

At autopsy the most striking changes were noted in the heart, which weighed 500 g. The epicardium contained multiple small petechial hemorrhages. The coronary arteries, both atria, and the right ventricle were normal, as were the valve cusps. However, the left ventricle was markedly hypertrophied. A large old intraluminal thrombus filled 70 to 80 percent of the ventricular cavity, and overlaid a thickened, fibrotic endocardium measuring 2 mm. The myocardium was also thickened, measuring almost 2 cm. At the apex was a small fresh clot beneath the large mural thrombus. Microscopy revealed the thrombus, with granulation tissue both superficial and deep to the fibrotic endocardium. Thick bands of loose fibrous tissue extended deep into the myocardium, with hypertrophied myocardial fibers and foci of chronic inflammatory cells.

Other findings at autopsy included hydropericardium with 200 ml of serosanguineous fluid, bilateral hydrothorax, ascites, edema of the brain, and acute and chronic passive hyperemia of lungs, liver, and spleen. Both kidneys were enlarged, weighing 250 g each and on microscopy showed moderate periglomerular thickening, hypercellular glomerular tufts, irregular nodular thickening of the mesangium, and some thickening of the afferent arterioles. Many lymph nodes were enlarged, and on section showed follicular hyperplasia, eosinophilic deposits in the follicle centers, and inflammatory infiltrates of the sinusoids. The bone marrow was hypercellular, with marked myeloid proliferation, eosinophilia, and plasmacytosis.



FIGURE. 3 Autopsy specimen, left ventricle, showing normal mitral valve cusp above and fresh thrombus at apex below. The whitish endocardium is greatly thickened, and the ventricular cavity is almost obliterated by an old, organized mural thrombus.



FIGURE 4. Low power section of left ventricle wall showing myocardium above, mural thrombus below, and thickened endocardium between.

Discussion

Loeffler's endocarditis apparently is the cardiac manifestation of a systemic disorder of unknown etiology. Virtually every case report tells of variable extra-cardiac symptoms and physical findings, with laboratory or autopsy evidence of inflammatory infiltrates containing eosinophils in multiple organs. Low-grade fever, central nervous system sym-

toms, peripheral neuropathy, and asthmatic attacks have been reported, with palpable lymph nodes, hepatomegaly, and splenomegaly. Azotemia is sometimes found, and a leukemoid reaction with profound eosinophilia is frequent, as in the present case. Inflammatory infiltrates, containing eosinophils have been found in lymph nodes, lungs, liver, spleen, and kidneys, and some observers have reported evidence of arteritis. No previous references have been found to pancytopenia, although several observers report the disappearance of eosinophilia and of the leukemoid reaction prior to death. It is conjectural whether or not the three days therapy with 6-mercaptopurine or the administration of chloramphenicol played a significant role in producing the ultimate pancytopenia in this case, but it is to be noted that anemia and thrombocytopenia were present prior to their administration, and the marrow was hypercellular at necropsy.

This case is of interest in that eosinophilia was known to have been present for at least three years prior to the onset of cardiac manifestations. However, the patient was asymptomatic except for his duodenal ulcer, and remained so until a few weeks prior to death. His symptoms at first were those of a systemic disease with anemia, followed by intractable heart failure, pulmonary edema, and death. Lymphadenopathy, hepato-splenomegaly, and azotemia were also noted. The autopsy findings in the heart were typical of Loeffler's endocarditis. This diagnosis had been considered before death but the profound leukemoid reaction and other systemic manifestations led to the other clinical diagnoses mentioned. The literature reveals, however, that systemic manifestations are the rule rather than the exception in Loeffler's endocarditis.

Various etiologies have been proposed for this syndrome. Allergy has been considered because of the occasional bronchospasm and the eosinophilia. Parasites have been proposed because of the eosinophilia. A few cases reported from Africa were associated with filariasis, but in the great majority of instances no parasites have been identified. The occurrence of arteritis in some cases has led to the postulate that this is a variant of

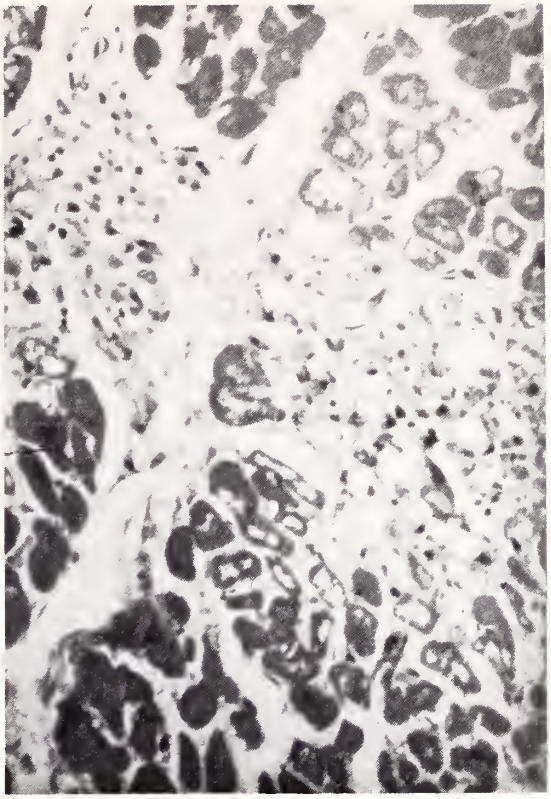


FIGURE 5. High power magnification of myocardium showing degenerated fibers and inflammatory infiltrate.

polyarteritis nodosa. However, the typical necrotic arterioles are lacking, and arteritis is not consistently present. Infection with a virus or other unidentified agent is another unproven postulate. More light may be shed when a greater understanding of the function of the eosinophil is gained. Meanwhile, it would appear that Loeffler's endocarditis is a systemic disease of unknown cause with an eosinophilic inflammatory response followed by fibrosis in multiple organs. This is most profound in the endocardium, leading usually to death from intractable heart failure. Since diagnosis is essentially a post-mortem one, it is not known whether non-fatal cases occur.

The presence of eosinophilia in a patient with obscure heart failure is the setting in which Loeffler's endocarditis is to be suspected. Sometimes the eosinophilic leukemoid reaction is so intense as to suggest leukemia, and this has been a troublesome differential diagnosis in several other reported cases. Trichinosis and polyarteritis nodosa are two other diseases in which heart failure and eosinophilia may occur.

From the cardiac standpoint, constrictive pericarditis, primary myocardial disease, infiltrative myocardiopathies such as amyloid disease, and the processes affecting primarily the parietal endocardium are to be differentiated. The pathophysiology is similar to that of constriction. In fact, "constrictive endocarditis" has been proposed as a descriptive name. Two cases have been reported in which appropriate studies were performed. In one, pericardial exploration was carried out because of pressure curves obtained on right heart catheterization that were typical of constriction, but the pericardium was normal and the diagnosis was ultimately made at autopsy.[5] Another case reported from France revealed the pressure curve of constriction, and on cinecardiography the ventricular cavity was noted to be small, with little change in size between systole and diastole.[6]

In addition to Loeffler's disease there are three idiopathic processes affecting primarily the parietal endocardium which need to be differentiated.[7] Endocardial fibroelastosis has a worldwide distribution, and occurs chiefly in infancy but occasionally in older persons. Elastic fibers as well as collagen fibers are involved, but the process is limited to the heart. Endomyocardial fibrosis has been encountered chiefly in tropical Africa. There is little or no systemic reaction and no eosinophilia, but the endomyocardium of either or both ventricles may be involved in an obliterative fibrotic process which sometimes produces mitral or tricuspid insufficiency due to encroachment on the papillary muscles. Mural thrombi and embolism are common. Becker's disease is an even more obscure syndrome. It has been reported only from South Africa, and resembles Loeffler's disease in that systemic reactions, mural thrombi, and embolism are common. It is differentiated in that the infiltrates and hematologic reaction are neutrophilic rather than eosinophilic.

Since the diagnosis has almost always been at autopsy, there is little mention of treatment other than routine measures for heart failure, i.e., digitalis, diuretics, salt restriction, and oxygen. On the rare occasions when steroids were used they did not appear to be helpful. However, it would now appear that a tentative clinical diagnosis can be made if it is considered in patients with obscure heart failure and eosinophilia. It would be supported by right heart catheterization showing the pressure curve of constriction and by angiography revealing encroachment on the ventricular cavities. Trial therapy with steroids and possibly anticoagulants seems indicated under these circumstances.

Summary

A fatal case of fibroplastic endocarditis with eosinophilia is reported. Necropsy revealed a large, organized mural thrombus in the left ventricle together with marked fibrotic thickening of the endocardium and eosinophilic inflammatory infiltrate in the myocardium. These findings were consistent with 49 fatal cases previously reported in the world literature. When the syndrome is suspected in patients with obscure cardiomyopathy and eosinophilia, it may be supported if right heart catheterization reveals the pressure curve of constriction and cineangiography reveals encroachment on the ventricular cavities. Under these circumstances trial therapy with steroids and anticoagulants seems justified, as the clinical course in the known cases hitherto has been relentlessly downhill and ultimately fatal.

Bibliography

1. Loeffler, W.: Endocarditis parietalis fibroplastica mit Blut eosinophile, *Schweiz. Med. Wschr.* 66: 817-820, (Aug.) 1936.
2. Brink, A. J., Weber, H. W.: Fibroplastic parietal endocarditis with eosinophilia: Loeffler's endocarditis. *Amer. J. Med.* 34: 52-70, (Jan.) 1963.
3. Hoffman, F. G., Rosenbaum, R., Genovese, P. D.: Fibroplastic endocarditis with eosinophilia (Loeffler's endocarditis parietalis fibroplastica): Case report and review of literature. *Ann. Intern. Med.* 42: 668-680, (March) 1955.
4. Mautner, L. S., Harris, F.: Fibrosing endocarditis with eosinophilia: Loeffler's endocarditis parietalis fibroplastica. *Canad. Med. Ass. J.* 95: 1201-4, (Dec.) 1966.
5. Clark, G. M., Valentine, E. Blount, S. G.: Endocardial fibrosis simulating constrictive pericarditis. *New Eng. J. Med.* 254: 349-355, (Feb.) 1956.
6. Godeau, P., Gerbaux, A. Ferrane, J. Rosenthal, D., Siquer, F.: A propos d'un cas d'endocardite a eosinophiles. Etude anatomo-clinique angiographique et hemodynamique. *Societe Med. des Hop de Paris,* 115:1223-1235, (Nov.) 1964.
7. Davies, J. N. P.: Some considerations regarding obscure diseases affecting the mural endocardium. *Amer. Heart J.* 59: 600-631, (April) 1960.

A "cold" fact



NTz® delivers relief of nasal symptoms

The *first spray*—1 or 2 squirts—of NTz opens the inferior part of the common meatus. The *second spray*, a few minutes later, shrinks the turbinates to promote adequate sinus drainage and ventilation—to help prevent sinusitis. Dosage may be repeated every three or four hours.

The fact is, NTz is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy (in full adult strength) to shrink nasal membranes and allow comfortable breathing.

Thenfadil® HCl 0.1%, a topical antihistamine to help relieve itching and rhinorrhea.

Zephiran® Cl 1:5000, an excellent wetting agent and antiseptic preservative to aid rapid spread of components.

NTz, for temporary relief of nasal symptoms, is well tolerated, but overdosage should be avoided.

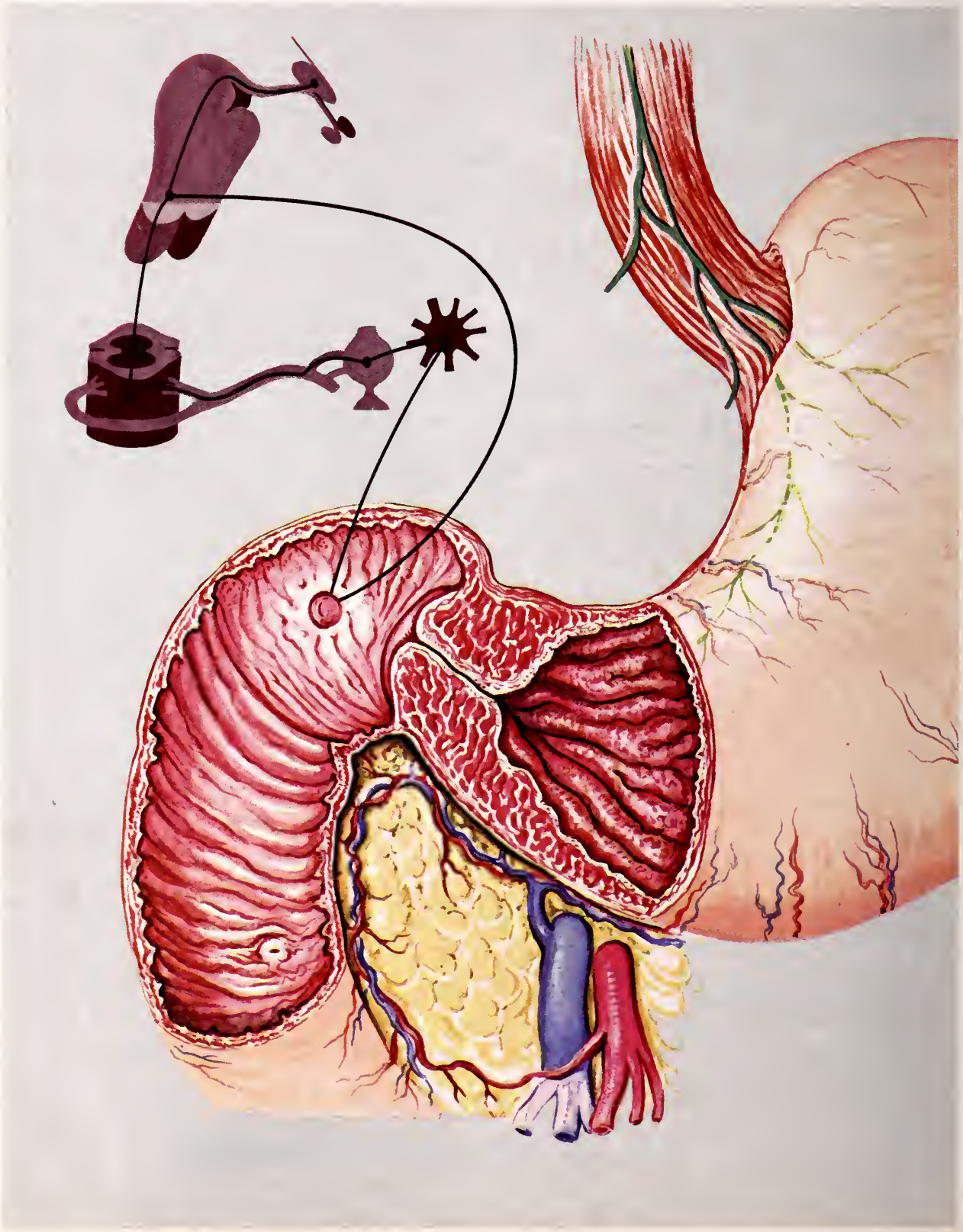
Available: NTz Nasal Spray in squeeze bottles of 20 ml.; NTz Solution in bottles of 1 oz. with dropper.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

(1286M)

Healing the ulcer crater



Pro-Banthīne®

brand of
propantheline bromide

blocks ulcerogenic autonomic impulses

Therapeutic Activity—Pro-Banthīne blocks ulcerogenic impulses at both parasympathetic effector sites and ganglia and at sympathetic ganglia.

This dual action, a capacity quite beyond that of belladonna derivatives, has been shown repeatedly to reduce gastric secretion, to suppress gastrointestinal motility and to relieve ulcer pain.

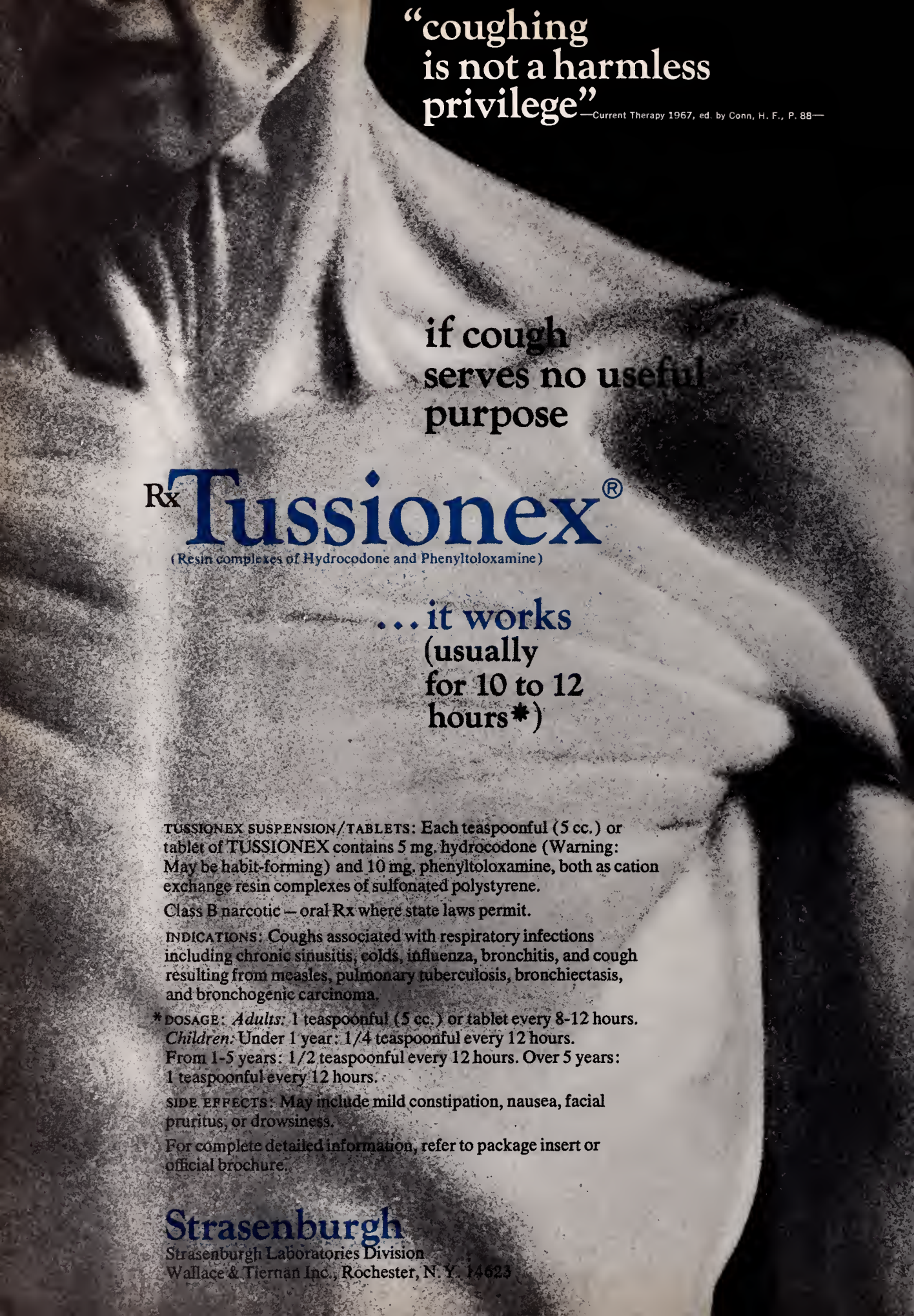
Healing Environment—Thus, Pro-Banthīne, together with other standard measures, creates a favorable environment to hasten healing of the ulcer.

So widely is this ability recognized that for years Pro-Banthīne has been the most widely prescribed medication for treating peptic ulcer.

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.
Contraindications: Glaucoma, severe cardiac disease.
Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.
Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

981 4/69

SEARLE *Research in the Service of Medicine*


"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
℞ Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic — oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

The Genesis and Treatment of Hyperadrenalism†

FRANK GLENN, M.D.*
New York, New York

TO BE added to the long list of American surgeons who have been invited to deliver the Davis W. Yandell lecture is an honor and privilege for which I am grateful. Professor Yandell's philosophy of medical education was of the nature that has done so much to advance surgery in this country. First, his broad concepts were solid and emphasized the importance of the individuality of the young man who came to him for training and second, he imparted to him the fundamentals of medicine as well as those in the more limited area of surgery.

In the study of disease in man a reasonable knowledge of anatomy, embryology, histology, biochemistry, physiology and pathology is essential, in my opinion, to understanding the processes involved. My subject for this occasion was selected because of first, my interest in the adrenals and second, the opportunity to present to you as future leaders in the medical profession an example of the orderliness these divisions of the medical sciences afford in discovery of methods to control, reduce and prevent disability. The specific diagnosis of most diseases related to the adrenal glands and their alleviation or cure have been accomplished for the first time within the past half century.[1]

During this same period factual knowledge in the health field has accumulated in such staggering amounts that its assimilation is beyond the capacity of most of us. Because of this, much attention is being given to revision of the curriculum of our medical schools. In many institutions the time previously allotted to the basic subjects has been reduced to add new subjects. Thus students are ill equipped to comprehend and evaluate the clinical manifestations of disease and the disability they may cause. I much favor adding new developments to these fundamental divisions. Currently almost every medical school throughout the United States is engaged in rearrangement of its curriculum, and while it is anticipated that these innovations in medical education will eventually swing back in balance with the basic and fundamental in reasonable perspective, it is abundantly evident that at present many are actual handicaps for the student in preparing for the responsibilities of the profession.

THE ADRENALS

Anatomy

The adrenal glands are paired organs which lie between the vertebral column and the medial aspect of each kidney. The glands are surrounded by fat, the amounts varying according to the general intra-abdominal obesity of the individual. The average weight of both glands in the adult is between 8 and 12 grams. Generally, their total weight in women is somewhat more than in men. The adrenal glands are beige to light brown and can be distinguished from the surrounding fat by their darker color and firmer consistency. The average dimensions of the adrenals are about 3 x 5 x 0.4 cm. The increased weight of diseased glands is associated with an increase in thickness.

The vascular supply and drainage of the adrenal gland are unlike those of any other organ, in that the arterial and venous vessels do not parallel each other. Most standard textbooks list the arterial supply of the adrenal as being from three separate sources. The superior artery is a branch of the inferior phrenic, the middle artery is a direct branch from the aorta, and the inferior branch arises from the corresponding renal artery. The gross venous drainage of the normal or hyperplastic suprarenal is quite simple. All or almost all of

†*Sixteenth Annual Yandell Lecture, jointly sponsored by the Louisville Surgical Society and the department of surgery, University of Louisville School of Medicine, November 25, 1968*

**Lewis Atterbury Stimson professor of surgery emeritus, Cornell Medical College, and consultant in surgery, New York Hospital*

the veins channel into one large structure—the central adrenal vein.

The lymphatics lie in the connective tissue trabeculae that penetrate the capsule and pierce the columns of cortical tissue. The medullary lymphatics eventually form a plexus surrounding the adrenal vein and ultimately drain into the lateral aortic nodes.

The nerve supply of an adrenal gland can also be divided into two separate categories. No definite cortical innervation has been shown. The greater nerve supply to the medulla is autonomic in origin, arising from the sympathetic preganglionic fibers from T-10 to L-1. The fibers emerge with the anterior rootlets and pass to the sympathetic ganglia. These nerves go through the celiac, aorticorenal, and renal ganglia. In addition, there are branches from the splanchnic nerves which bypass the ganglion and go directly to the medulla. Finally, additional fibers may come from the phrenic nerves and the renal plexus.

Embryology

The adrenal or suprarenal gland is really two separate functional structures combined within a single capsule. It develops from two individual elements, the cortex from the mesoderm and the medulla from ectodermal chromaffin tissue. The cortical portion of the adrenal can be first recognized in about the fifth or sixth week of fetal life as a group of cells originating from the development of peritoneal epithelium at the base of the dorsal mesentery in the cranial end of the mesonephros. These cortical structures are relatively huge, being even larger than the kidney at about the fourth month of fetal life.

There are occasional developmental anomalies of the adrenal cortex, i.e., multiple primordia or secondarily separated portions may form accessory glands which are usually composed of cortical tissue only. Aberrant cortical tissue may be found adjacent to the adrenals, in the spleen, below the kidneys in the retroperitoneal space, or close to the testes or ovaries.

The structures composing the chromaffin system arise from the cells of the primitive autonomic system, which are multipotential, and originate in the ectodermal area where they arise from the neural crest and differentiate into the primitive sympathetic ganglion cells. One group becomes the endocrine elements that have the characteristic property of staining brown with chromium salts and are therefore called chromaffin cells. The adrenal medulla, which is the most prominent component of this organ system, develops from a group of cells that migrate from the primitive ganglia of the celiac plexus. By the seventh week of development, masses of these developing chromaffin cells can be seen in the medial side of a well-developed cortical rudiment. Other sites of sympathetic tissue include the paraganglia and the aortic bodies. The paraganglia approximate to the autonomic ganglia and are known as paraganglion chromaffin bodies, the organ of Zuckerkandl being the most obvious.

Histology

The vast preponderance of the adult gland is made up of cortex. This can be divided into three layers microscopically: (1) the zona glomerulosa, producing primarily mineral corticoids; (2) the zona fasciculata, where the glucocorticoids are elaborated; and (3) the zona reticularis, the source of estrogens and androgens. The central glandular tissue is the medulla, where potent pressor substances are secreted. In general, the cortical cells are quite epithelioid in appearance. They are relatively large and have a prominent nucleus, which is likely to contain two or more well-defined nucleoli. The cytoplasm is rather pale, owing to the abundance of lipids. This renders the Golgi apparatus and mitochrondria easily recognized.

The medulla of the suprarenal gland is composed of columns of regularly arranged polyhedral cells. The cytoplasm tends to be rather granular. These cells stain brown with potassium dichromate, and because of this they are called chromaffin cells. With histochemical techniques it can be demonstrated that some groups of medullary cells produce epinephrine while others produce norepinephrine.

Biochemistry and Physiology of the Adrenal Cortex

More than 50 steroids have been isolated from the ardenal cortex.[2] The major biologic activities of the adrenal steroids may be classified as: I. Glucocorticoids—those influencing principally the intermediary metabolism of carbohydrates, protein and lipids and exhibiting an ef-

fect in suppressing certain inflammatory processes; II. Mineral Corticoids—those with potent effects on electrolyte transport; and III. Androgens and Estrogens—those with androgenic (male) and those with estrogenic (female) actions.

The first group are the glucocorticoids—cortisol and corticosterone make up by far the largest proportion, with cortisol accounting for the major glucocorticoid activity. The second group include aldosterone and desoxycorticosterone; however, the former accounts for most all of the mineral corticoid activity. The third group, the androgenic steroids, are varied in their effect in infancy and adulthood as well as between the sexes.

I. *Glucocorticoids*: The action of the secreted steroids, the cholesterols, may be limited in duration and it is therefore essential that the concentration of steroid in the plasma and the intensity of its action be under continuous dynamic control.

Cortisol: The secretion of cortisol is believed determined by the rate of release of adreno-corticotropin (ACTH). The elaboration of ACTH is influenced by centers in the higher nervous system which relay information through the limbic system to the hypothalamus. Various peripheral receptors sensitive to noxious environmental stimuli carry information directly to the hypothalamus.[3] Thus, there are psychologic phenomena such as fear, anxiety, anger and frustration that act through the higher central nervous system, whereas the noxious stimuli (pain) influence the hypothalamus by more direct neural connections. The rate of release of ACTH represents the balance between the excitatory influence of the central nervous system and the inhibitory influence of the corticosteroids. Cortisol has an important physiologic role in regulating the rate of release of ACTH from the pituitary gland.

It has been estimated that in man the basal secretion of ACTH is somewhat less than one unit per day and the plasma concentration in the morning is about 0.25 mU per cent. The plasma ACTH and cortisol concentrations show a constant pattern of cyclic variation within an approximate 24-hour period in normal individuals not subjected to stress. The plasma levels are highest between the hours of 6:00 and 9:00 a.m. and decline slowly thereafter to values close to zero around midnight. This diurnal rhythm[4] is dependent on the sleep pattern and independent of food intake, exercise and light; however, when a subject changes longitudinal location rapidly (e.g., New York to Tokyo), this cycle does not adjust to the new time for approximately one week.

Metabolism of Cortisol: In the normal adult, 8 to 25 mg of cortisol are produced per day. Cortisol exists in the plasma in three different physical-chemical states: (1) free or unbound in aqueous solution, (2) albumin-bound, and (3) alpha-2 glycoprotein-bound (transcortin). In a normal subject with a normal plasma cortisol level, about 90 per cent of the cortisol is protein-bound.[5]

Conventional chemical assay methods for plasma cortisol measure both the nonprotein-bound and protein-bound steroid. At plasma cortisol concentrations within the normal range of 5 to 20 ug per cent, 5 to 10 per cent of the total plasma cortisol is unbound; however, at concentrations exceeding 20 ug per cent, transcortin is completely saturated, and of the excess cortisol, 70 to 80 per cent binds to serum albumin. The importance of the steroid protein-binding resides in the effects that it may have on the distribution, transport, excretion and biotransformation of the steroid. Most of the cortisol and its metabolites are excreted in the urine.

The enzymatic mechanisms that contribute to the disposal of cortisol may be deducted from the nature of the urinary metabolites. *Less than 1 per cent of the administered steroid escapes transformation and is excreted unchanged.* An equivalent amount is also excreted as cortisone. These metabolites represent about 75 per cent of the total urinary radioactivity, and 25 per cent remains as labeled products not extracted by dichloromethane after glucoronidase hydrolysis.

II. *Mineral Corticoids*: Aldosterone is the most potent mineral corticoid synthesized by the adrenal gland.[6] It has an effect on electrolyte metabolism similar to that of desoxycorticosterone, but is 30 to 40 times more potent. It differs from other adrenal steroids in that it is derived primarily from the outer adrenal

cortical layer, the zona glomerulosa. Since the regulation of aldosterone is important for electrolyte and extracellular fluid volume homeostasis, it is not surprising that alterations in electrolyte intake and plasma electrolyte concentrations may alter aldosterone secretion. Aldosterone secretion is consistently increased with sodium restriction, and decreased with sodium loading. When dietary potassium is restricted aldosterone secretion decreases, and with potassium loading it is increased.

Studies on the mechanism leading to the increased secretion of aldosterone following fluid and electrolyte loss, sodium deprivation, and experimental conditions associated with marked changes in intravascular volume indicate that the immediate stimulus is humoral. Current findings favor the view that the kidney is the site of origin of this important humoral agent.

Metabolism of Aldosterone: On a normal sodium intake (70-120 mEq/day) the rate of production of aldosterone ranges from 40 to 200 ug/day. The mean production in the adult is about 100 ug/day. Approximately two thirds of the plasma aldosterone is exclusively bound to plasma albumin, and the total bound and unbound plasma aldosterone level ranges from 3 to 15 ug per cent as determined by both direct and indirect assays. The metabolic clearance rate of aldosterone is approximately 1500 liters per day. This value approaches that of hepatic blood flow and suggests that aldosterone is almost completely removed from the plasma after one passage through the liver. The data on urinary excretion also demonstrate that aldosterone is rapidly metabolized and excreted in the urine, and less than 5 per cent is excreted in the bile. Orally administered aldosterone appears to be completely converted to inactive products as evidenced by absence both of biologic activity and of any free aldosterone in the urine.

Most of the extra-adrenal transformations of the steroids are essentially "detoxification" reactions tending to decrease the effective concentration of the active hormones or to diminish markedly their activity. The effective concentrations of the steroids may be altered by enzymatic conversion to an inactive compound, by urinary or biliary excretion, or by removal of an active steroid to an inert area, i.e. fat and physical inactivation. The importance of the liver in metabolism of the steroids had been shown both *in vivo* and *in vitro*.

III. *Androgens and Estrogens:* The over production of androgens by the adrenal cortex gives rise to the adreno-genital syndrome.[7] A partial defect in synthesis of 21-hydroxylated steroids produces simple virilism, whereas virilism with sodium wastage is thought to represent a more severe defect in synthesis of 21-hydroxysteroids. In the simple virilizing form, the precursors of cortisol, 17-hydroxyprogesterone and 11, 17-dihydroxyprogesterone, are present in increased amounts. This gives rise to an increased urinary excretion of metabolites of these two steroids, pregnanetriol and 11-ketopregnanetriol, respectively. Because of the severity of the enzymatic defect in the salt-losing variety, there is also a decreased production of aldosterone, and this accounts for the renal sodium wasting. Adequate amounts of the glucocorticoids suppress the overproduction of ACTH and cause a marked decrease in adrenal androgens.

Biochemistry and Physiology of the Adrenal Medulla

Since chromaffin cells occur predominantly in the adrenal medulla and are the sole source of epinephrine, the plasma level and urinary excretion of free epinephrine may be correlated quite specifically with adrenal medullary activity. Epinephrine must first enter the blood before it can reach the receptor site. The biologic action of this hormone[8] is direct, and the effect dependent upon its level in the blood. Most of the norepinephrine enters the circulation from adrenergic nerve endings[9] rather than from the adrenal, and thus the plasma and urinary free norepinephrine are normally related to adrenergic nerve activity. Catecholamines contain a catechol nucleus (benzene ring with two adjacent hydroxyl groups) and an amine side chain. The relative amounts of the catecholamines, epinephrine, norepinephrine, and dopamine in the adrenals vary somewhat with age. Chromaffin tissue (adrenal medulla) contains an additional enzyme which converts norepinephrine by N-methylation to epinephrine. This N-methyl transferase requires S- adenoxylmethionine as the methyl donor.

Although normal subjects show a relatively constant pattern of catecholamine metabolites, this is not true for patients with tumors arising from the medulla. These patients may show a relative preponderance of free urinary catecholamines as compared with the metanephrines and vanilmandelic acid (VMA). On the other hand, some patients excrete relatively more of the metabolites than the free catecholamines. The larger tumors with a higher total content of catecholamines and lower rate of turnover of the catecholamines tend to excrete a relative excess of the metanephrines and VMA as compared to the free catecholamines. This latter finding is probably best explained by the fact that substantial quantities of the catecholamines are metabolized directly by the tumor.

Clinical Hyperadrenalism

Tumors arising from and hyperplasia of medullary and eortical adrenal tissue produce a marked inerease of those substances that they elaborate ordinarily. Sueh a state is known as hyperadrenalism and is further defined according to whether the medulla or cortex is involved. The elinical manifestations that result are now well known and readily recognized. Those most frequently encountered are chromaffin tumors, pheoehromoeytomas, arising from the medullary tissue, Cushing's syndrome, aldosteronism associated with pathological changes originating in the adrenal cortex and adrenogenital syndrome. Rarc and less well understood are the group of adrenogenital abnormalities and related androgenic steroid fluctuations, also of cortical origin.

CHROMAFFIN TUMORS

Pheochromocytomas are neoplasms derived from chromaffin eells of the adrenal medulla or other components of the sympathetie nervous system. Probably 90 per cent of these tumors arise from within the adrenals and 10 per eent from extra-adrenal ehromaffin tissue. They may cause a persistent or a paroxysmal hypertension frequently associated with serious eomplications. In 1951 unreeognized pheochromocytomas were estimated by Graham [10] to account for approximately 1,000 deaths annually in this country.

In recent years there has been an inerease in the number of patients suspeeted of having pheochromocytoma. Using newer diagnostic measures during the last five years the diagnosis is confirmed more readily. Headache probably has been the most eommon complaint although many patients were aware of flushing, blanching and exeessive intermittent sweating. A majority had persistent hypertension. Most, but not all, were underweight. A few patients have been above ideal weight and a proportionate number have been in the normal range. The nature of the symptoms, in general, is related to the major pressor substance produced by the tumor. When the pressor substance is norepinephrine, and this is mueh more eommon, the patient presents with hypertension, taehycardia and headaches with relatively little in the way of metabolic effeets. Where the major substance is epinephrine as oeeurs in a small minority, the increased manifestations of hypermetabolism such as sweating, flushing and diabetes, may overshadow the hypertension.

Laboratory Diagnosis: The urinary eateeholamines are representative of breakdown products of the important vasopressors. At present, probably the most reliable determinations for diagnosis are those for metanephrine and normetanephrine in the urine. With regard to provoeative tests that include histamine and phentolamine, we believe they are unneeessary and the former may be dangerous.

Management: When diagnosis has been estabished, management of the patient with chromaffin tumors may be divided into three phases: (1) evaluation and eontrol of clinical manifestations; (2) anesthesia and operation; (3) postoperative return to recovery. The introduetion of propranolol is the latest milestone in the management of these patients. Prior to its use, ventrieular arrhythmias constituted a potential hazard of eoncern to both anesthesiologist and surgeon because, too frequently, they preceded unantieipated death. Using propranolol we have had no diffieulty in eontrolling and preventing the ventricular arrhythmias. There are two drugs, phentolamine and phenoxybenzamine, which in effect wear out the tumor. The first drug used was phentolamine in doses up to 600 mg a day orally. Thc drug is effective in the majority of patients. At the present time phenoxybenzamine in doses starting at 10-30 mg a day will control blood pres-

sure. It is superior because its action is longer than that of phentolamine.

CUSHING'S SYNDROME

Cushing's syndrome[11] refers to a set of clinical manifestations and metabolic abnormalities characterized by plethora, truncal and facial obesity, mild or latent diabetes, osteoporosis, hypertension, easy susceptibility to bruising, purplish striae, mental changes; and in women, menstrual disturbances, hirsutism and acne without overt evidence of virilism. In all forms of this syndrome, regardless of cause, the abnormal clinical and laboratory findings result from a chronic excess of cortisol (hypercortisolemia) due to overproduction of cortisol by the adrenal cortex. In women, certain of the signs and symptoms are related to an associated overproduction of adrenal androgens.

Pathogenesis and Pathology: In Cushing's syndrome the one common denominator is hypercortisolemia due to an abnormal increased production of cortisol. Hyperfunction (hypersecretion of cortisol) with or without generalized enlargement of the adrenocortical tissue accounts for by far the largest number of adult cases of the syndrome. The hyperactive gland may frequently be within the limits of normal size, weighing 4 to 6 grams; hyperplastic glands may weigh as much as 50 grams but usually their combined weights are less than 25 grams.

Diagnosis: A significant elevation of the serum cortisol and urinary 17-hydroxycorticoids is essential to establishing the diagnosis of Cushing's syndrome. Serum cortisol determinations up to 22-24 micrograms per cent are considered to be within the normal range with a diurnal variation in the afternoon. While most patients with Cushing's syndrome are above this, there are some who have high normal levels in the morning that do not decrease in the afternoon. Urinary 17-hydroxycorticoids for the normal male range from 12-14 mg per cent per 24 hours and for the female from 8-10 mg per cent.

As knowledge of the condition has increased, it has become apparent that Cushing's syndrome may be caused by at least four separate entities. The first and most common of these is dysfunction of the hypothalamic-pituitary axis, with resulting adrenal hyperfunction and usually adrenal hyperplasia. The patients in this group may be subdivided into those in whom an obvious pituitary tumor is present, and the larger percentage in whom there is no clinical or roentgenologic evidence of pituitary involvement. Second, there are those who have an autonomous adenoma which accounts for the clinical symptoms. Next, there are instances of adrenal cortical carcinomas which produce a rather fulminant disease and, finally, there are extra-adrenal carcinomas which are believed to elaborate an adrenocorticotropic hormone-like substance, resulting in marked adrenal hyperplasia and hyperfunction. These extra-adrenal malignant tumors are most frequently oat cell carcinomas of the lung and thymic neoplasms. However, other carcinomas have been reported, such as those arising from the esophagus, biliary tract and colon which cause this syndrome.

Differential Diagnosis: The important diagnostic test for differentiating between patients with adrenal hyperfunction and those with autonomous tumor is the dexamethasone suppression test. Ordinarily, the patient with adrenal hyperplasia or hyperfunction, or both, experiences a suppression of secretion of more than 60 per cent after the administration of 2 milligrams of dexamethasone per day for three days and then 8 milligrams for an additional three days. In the absence of significant depression, one may presume that an autonomous tumor is present. Thus the suppression with dexamethasone has become established as a means of differentiating between diffuse hyperplasia, benign adenoma, and carcinoma of the adrenal cortex.

The availability of replacement therapy has rendered total bilateral adrenalectomy a reasonably safe procedure, with predictably good results for hyperplasia of the adrenal cortex, the most frequent finding in patients with Cushing's syndrome.

Adenomas of adrenal cortex are encountered in about one-quarter of the patients with the syndrome; complete recovery follows excision. Carcinomas arising from the adrenal cortex are associated with limited life expectancy and are unresponsive to present available measures. Even more discouraging are those occasional instances when Cushing's syndrome and ad-

renal cortical hyperplasia are due to cancer arising elsewhere.

HYPERALDOSTERONISM

Aldosterone is the most potent mineral corticoid synthesized by the adrenal. It has an effect on electrolyte metabolism similar to that of desoxycorticosterone but is 30-40 times more potent. At small concentrations it acts to augment renal tubular reabsorption of sodium by stimulating the sodium for hydrogen ion exchange and sodium for potassium in the distal renal tubules and the first part of the collecting tubules. Thus as a consequence of renal ischemia (Goldblatt clamp) aldosterone secretion may be increased in malignant hypertension or unilateral renal disease. On a normal sodium intake (70-120 mEq/day) the rate of production of aldosterone ranges 40-200 ug/day with an average of 100 ug. In excess it manifests itself by hypertension in nonedematous patients. Neuromuscular changes such as muscle weakness and paralysis occur only in the presence of a marked hypokalemia. Asthenia may accompany hyperaldosteronism of a lesser degree.

The three most useful specific diagnostic procedures are (1) failure to increase a low plasma renin activity during volume depletion (sodium restriction, upright position), (2) failure to suppress aldosterone secretion during volume expansion (sodium loading, desoxycorticosterone), and (3) increased urinary potassium loss during volume expansion by sodium loading.[12]

Patients with secondary aldosteronism and elevated plasma renin activity may also fail to depress their aldosterone production significantly after chronic sodium loading, because the induced volume expansion may be ineffective in increasing their blood volume.

Differential Diagnosis: Syndromes may present one or more of the cardinal signs common to primary aldosteronism—i.e., hypertension, hypokalemia, hyperaldosteronism. Therefore, the differential diagnosis must include an evaluation of the other disorders that manifest one or more of these features. The combination of hypertension, hypokalemia, and hypersecretion of aldosterone may occur in essential, advanced, malignant, and renovascular hypertension; it may also occur after thiazide therapy for hypertension. Normal pregnancy is accompanied by a progressive increase in secretion of aldosterone beginning about midpregnancy.

Treatment: The diagnosis of primary aldosteronism should be firmly established before surgical exploration is undertaken. Prior to surgery, patients with signs of primary aldosteronism, especially children, should receive a short therapeutic trial with small doses of one of the synthetic glucocorticoids (dexamethasone, 1.5 to 2.0 mg/day for one week). If this therapy corrects the hypokalemia and hypertension and markedly decreases the urinmethasone , 1.5 to 2.0 mgffday for one week). If this therapy corrects the hypokalemia and hypertension and markedly decreases the urinary excretion of aldosterone, surgical exploration is not indicated, and the patient does not harbor an adrenal neoplasm. If a tumor is palpated in only one gland, that adrenal alone is removed. This does not exclude the presence of tumor in the other adrenal; nevertheless, the gland harboring the palpable tumor is removed. If *tumors* are found in both glands, an attempt is made to preserve a part of the normal adrenal tissue. Infrequently a patient with primary aldosteronism, unresponsive to small quantities of the synthetic glucocorticoids, may at surgery show bilateral diffuse or nodular hyperplasia. In this situation, a subtotal or bilateral total adrenalectomy should be performed.

ADRENO-GENITAL SYNDROME

The adreno-genital syndrome[13] is manifested by virilization and feminization and is the result of distortion of hormone production within the adrenal cortex. There are two types. The first is congenital and is associated with an inherited defect in the enzymatic steps of hydrocortisone production; the second is the acquired and is the result of tumor growth or hyperplasia of the cortex.

The clinical manifestations of congenital adreno-genital syndrome range from minimal mascularization in infancy to life-threatening adrenal crisis with sodium depletion. The diagnosis is commonly made by finding abnormally increased 17-ketosteroids in the urine. The treatment is based on the suppression of the elevated 17-ketosteroids by glucocorticoids, such as prednisone or cortisone given daily.

The prognosis in mild cases is good, but in the more severe it is unpredictable and may progress from one complication to another.

Acquired adreno-genital syndrome is often rapid in onset, almost always causing virilization in the female and sexual precociousness in the adolescent male. Feminization is seldom observed. Adenoma and carcinoma arising from the cortex are usually the causative lesion although hyperplasia with manifestations of Cushing's syndrome does occur. More than half of the cases occur prepubertally and over 75 per cent are in females. The tumors may be benign adenomas or carcinoma, although histological assessment may be difficult. Although pleomorphism and mitotic figures are not common in adenomas, they may not always be prominent in carcinoma. Both types of tumors are usually well encapsulated. In general, the malignant tumors tend to be larger. Invasion of the capsule and veins is usually considered as evidence of malignancy; however, such changes may occur in either tumor. There appears to be a gradual transition from adenoma to carcinoma, and thus interpretation is made difficult. In many cases it is the test of time rather than the microscopic appearance of the tumor that determines the degree of malignancy.

Age of onset is of some diagnostic significance because an inherited defect of enzymatic action is often present amongst those under two years, whereas hyperplasia and tumors of the adrenal are most frequent between two and puberty. Beyond puberty, extra-adrenal tumors are to be suspected. In the adult female, hirsutism and acne are the first signs. Amenorrhea is common, and there may be clitorial hypertrophy and marked increase in libido. Hyperpigmentation, muscle hypertrophy, atrophy of the breasts, and deepening of the voice may also develop. In the prepubertal female, in addition to hirsutism there is a rapid statural growth with advance in osseous maturation. The time of occurrence of the tumors is variable; however, they do not occur immediately after birth, and this is helpful in differentiating them from congenital adrenal hyperplasia.

In the prepubertal male, the penis and prostate become enlarged, and pubic and axillary hair appears. Rapid growth of bone and muscle and deepening of the voice also occur. The testes remain small and immature, and these findings are to be contrasted with the gonadal maturation found in isosexual precocity. In the male these are characterized by gynecomastia, breast tenderness, loss of libido and potency, and in some cases, atrophy of the penis and diminution in the size of the testes. Occasionally, in addition to feminization, manifestations of Cushing's syndrome may be present.

Surgical excision of benign tumors provides amelioration with reversal in some instances. Malignant tumors have a grave prognosis regardless of heroic measures. Hyperplasia and accompanying manifestations of Cushing's syndrome are indications for total or subtotal adrenalectomy.

(Continued on page 302)

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

SPECIAL ARTICLES

CHP

GEORGE F. BROCKMAN, M.D.*

FOR OVER 50 years organized medicine has recognized the need for a national unified health policy, which could best be developed by a cabinet-level department of health, to coordinate all of the health programs of the federal government except those for the military services. No president or congress has accepted this concept. Federal health services have grown through hundreds of branches and agencies. The medical program of the Veteran's Administration exerts a direct influence on health care at every local level, as does Medicare, which is a joint venture of the Social Security Trust Fund and administrative sections of the Department of Health, Education and Welfare. Both are concerned with hospital services, yet Hill-Burton funds for hospital construction involve another administrative channel. The Office of Economic Opportunity has established programs for child health care (in most communities) and neighborhood health centers (in some communities) which are completely independent of other federal, state or local health agencies.

A lengthy list could be made of these programs that are well intended and perform useful services while pursuing their goals independently. All are incurring overhead costs and, even more important, consuming health manpower resources in a wasteful manner. We presented these thoughts as the Congress was considering the Public Health Services Act of 1966, and were rewarded with a new federal philosophy on health services.

As the superior authority, the federal government has pre-empted the better sources of tax revenue, and developed the most productive collection system. As a consequence, state and local governments, finding their tax revenues inadequate for public purposes, continually seek federal funds.

Congress has recognized numerous problems of local government as being of concern to the entire nation. Federal tax revenues have been voted as "grants-in-aid" for the financial support of state services. These appropriations are allocated to the states by formulae based on population, per capita income, area and other factors. They are usually on a matching basis, requiring the state to make a specified percentage contribution toward the program. There are over 400 such programs in the health and welfare area alone.

Congress attempts to apportion support to each program according to its importance on a national basis. This may not be the same rank as the importance of the program in a given state. State A with little tuberculosis and much venereal disease might have excess funds allotted for tuberculosis while their venereal disease program starved. In State B, with much tuberculosis and little venereal disease, the excess and inadequacy would be reversed.

Recognizing this, Congress placed in one fund its assistance for state public health programs previously supported as 16 "categorical" programs, allocating the federal money to each state as a "block" grant, with the state free to support each program according to local needs. These categorical programs are—cancer, chronic illness, dental disease, heart disease, mental illness, mental retardation, tuberculosis, venereal disease, neurologic disease, general health services, radiologic health, home health services and schools of public health.

In return for the freedom to shift these funds among the programs, each state was required to establish a single Comprehensive Health Planning Agency, to be responsible for the allocation of these categorical funds, and for preparing a master plan for all health activities within the state. A state Comprehensive Health Planning Council was established, to provide citizen guidance in keeping the State CHP Agency aware of local needs. The Congress was quite meticulous in spelling out the composition of a State Comprehensive Health Planning Council. It provides broad representation for the professionals in health care, but must have consumers of health services representing the majority of the membership.

The State Comprehensive Health Planning Council is advised of local needs by Regional Health Planning Agencies. This is a totally new structure in government, comprising the salaried secretariat of a Regional Comprehensive Health Planning Council, paralleling the relationship at the state level. On the Regional Council, health professionals have broad representation, but they must be in the minority. Majority membership was originally specified as follows:

Chairman, KMA Ad Hoc Committee on Comprehensive Health Planning

"Persons designated as consumers of health services shall be appointed who are specially qualified in their interest in health services related to schools, welfare programs, voluntary health programs, control of environmental health hazards, and rehabilitation services. Consumers representing mental health services and mental retardation services shall be nominated to the Council by the Regional Mental Health Retardation Board." Representatives of local government were later added by amendment.

Since we are all consumers of health services, the primary source of livelihood was made the basis for the distinction between the professional and consumer in the Comprehensive Health Planning Act. The typist in a hospital business office, though without health training, is regarded as a health professional; a tire dealer who is the trustee of a voluntary hospital is regarded as a consumer of health services.

In Congress this legislation was variously labeled as "The Partnership for Health Act" and "The Comprehensive Health Planning Act." Finally enacted as Public Law 89-749, it is the Comprehensive Health Planning Act of 1966, and in five sections provides:

a. *Formula Grants to the States for Comprehensive Health Planning.*
The initial allotment was $4,750,000 to the states for planning.

b. *Grants for Comprehensive Health Planning at the Area-Wide Level.*
"Area" is not sharply defined, but the intent is that it would be the largest territory in which there is a reasonably coherent community of interest in health matters.

c. *Grants for Training Health Planners.*
Non-profit organizations including universities are to use this money to explore the training of health planners. Presumably health planners will have some background in health, with additional skills in statistics, and in management and data-acquisition techniques.

d. *Grants to States for Public-Health Services.*
These are the "block-grants" to the states, replacing the specific allocation to the 16 categorical programs.

e. *Project Grants for Health Services Development.*
Specific funds are allocated, under the supervision of the Comprehensive Health Planning Agency, for the development of new methods in the delivery of health services or in training, provided they are limited to a small geographic area.

The Pluses of Public Law 89-749

Congress has embraced creative federalism in providing federal funds for health purposes at the local level, to be *expended* at the *discretion of a local authority*. The local authority has been thoughtfully designed to provide good representation for the health professionals, while avoiding professional aggrandizement by alloting majority membership to public representatives. Participation in Comprehensive Health Planning is voluntary; non-participants face no greater penalty than exclusion from federal funds. There are no punitive provisions. In eliminating appropriations for the categorical programs, Congress specifically makes it clear that this is in no sense a criticism of or dissatisfaction with any of these programs. There are additional disclaimers, requiring that activities under the Act shall not interfere with the established practices of physicians, dentists and other health professionals. The entire thrust of the Act is to establish a knowledgeable and sophisticated town meeting of those concerned with health, to reach decisions by concensus.

The Minuses of Public Law 89-749

Pessimists can predict stormy sailing for these Comprehensive Health Planning Councils, comprised as they are of a three-layer mix of health professionals, consumers and planners, and charged with exploring new areas in organizational relationships and in public administration.

Comprehensive in the title of the Act is a remarkable exaggeration. The only specific authority Congress has allocated to the Comprehensive Health Planning bodies is over the categorical programs. Less than 10 million dollars was appropriated as the federal contribution to CHP for the entire nation, and the annual appropriation by the end of June 1970 will only be 30 million dollars. This is less than 1/6 of the sums authorized for "innovative programs" in the Act itself.

KMA and Public Law 89-749

The Kentucky Medical Association has resoundingly endorsed Comprehensive Health Planning by direct action of the House of Delegates and by vigorous action by the Board of Trustees. The Board of Trustees worked diligently with the preceding and the present Governor to establish the State Comprehensive Health Planning mechanism on a sound basis. Every district trustee has specific responsibility for the furthering of Regional Comprehensive Health Planning in his district.

Despite its defects, we can accept the Comprehensive Health Planning Council as a workable body because of the experience most of us have had with voluntary hospitals. They are also a three-layer mix, composed of the health professionals, consumer representatives (the trustees) and planners (administrators). Remembering that our problems of today are the result of the planning of our brainy predecessors for answers to *their* problems, we recognize that there are no quick and easy answers.

To emphasize the negative aspect of the Comprehensive Health Planning Council is to overlook the fact that they can do a great deal of good without any large expenditure of funds. If the public representatives are well intentioned and are perceptive, they will recognize the need to orient themselves in the health care field. In doing this for possibly a period of two years they will be asking questions. The health professionals, particularly those on the councils, will recognize a responsibility to communicate freely and informatively with each other, the public represen-

tatives and the planners of the councils. In many instances it will develop that, in explaining our policies, practices and plans, we health professionals have not always planned adequately. There are many areas in which the relations of the health professionals, one to another, have not been worked out well. The mere process of explaning these to the public representatives and planners may well lead to solutions to problems. Frequently a clear definition of a problem makes the solution obvious.

In discharging its statutory responsibility for effective utilization of the funds of the 16 categorical programs on a local level, the council will begin to explore the operations of conventional public health services. The data for these studies will be available locally, and this will provide a valuable exercise for the planners in developing experience for the more advanced planning that we would hope the councils can undertake in the future. Certainly for two years, no more elaborate "planning" need be attempted than can be done with a pencil and paper, slide-rule or desk calculator.

The role of the planners will be to provide the councils with data. How many people need a service? Where do they live? How long are they in the hospital? What does it cost? For too many years, health care problems have been tackled by seat-of-the-pants navigation. The Title XIX Agency of Kentucky has had to make decisions on the level of medical services for the indigent, without knowing the number of indigents within 100,000. In no rural Kentucky County is there information on the distribution of the population by age group by income.

Public representatives of the lively sort, who are accustomed to analyzing problems and to decision-making can add immeasurably to the value of the councils. They will provide not only a forum for discussion and interaction, but they will stimulate discussion and investigation. Hopefully, they will bring a fresh perspective. Some of us who live daily with the problems of health care have difficulty in recognizing the forest from the trees.

Conclusion

KMA sees Comprehensive Health Planning as the brightest new development in the health care field in years. We are working to develop Comprehensive Health Planning Councils that accept the challenge and can function effectively in the scale that Congress has entrusted to them. After two or three years, we feel that Congress will be receptive to increasing the scope and authority of the Comprehensive Health Planning Councils, and possibly even be in a mood to accept a little comprehensive health planning for the federal establishment.

Complete Coverage

1969

KMA Interim Meeting

in the

MAY ISSUE



Neglected Opportunity

PHYSICIANS and their families comprise a highly respected and vital segment of any community in which they live. They are a part of every progressive and forward looking enterprise and almost always occupy positions of leadership in civic, cultural and health affairs. It is a centuries old tradition which has been maintained by the present generation despite much loose chatter and hullabaloo to the contrary and it will continue so as long as our high standards of selection, education and discipline are observed.

The objective of all intelligent and alert citizens, especially parents, is to continually upgrade and improve their community for their own enjoyment of life and for those who follow. There are innumerable agencies and organizations working toward this end and physicians are participants in all of them. Perhaps 90 per cent are active in churches; they are a part of all educational and cultural groups, recreational facilities, urban and social betterment, air and water cleanliness, and every endeavor for more healthful and abundant living.

Among these various agencies none is more effective and comprehensive in its interests than the community Chamber of Commerce wherever we may live. Unfortunately, this organization has often received less of our attention and support than is our fair share. Of the 2,800 members of the Louisville Area Chamber, only 71 of 813 active members of the Jefferson County Medical Society belong. True, we have better representation than other professions — teachers, attorneys, dentists, ministers—but that is a lame excuse for our poor participation. Many physicians are members of country clubs. True, there is more pleasure and recreation and family participation at the club, but the cost is proportionately higher and the community benefits are immeasurably less than achieved by a $75 a year membership in the Chamber.

Armin Willig, in a recent address to the Jefferson County Medical Society on the business aspects and obligations to our city, emphasized the benefits of the Chamber of Commerce to all residents of the city and surrounding area. In the open discussion afterward one member asked the oft repeated question, "Is not our membership fee in effect a contribution for which the physician can measure few tangible benefits?" The answer is, of course, "yes," but is not our much larger amount paid to church, or club, or Louisville Fund, or United Appeal—and even to our medical society—a contribution to a cause or a profession for which tangible benefits are hard to measure?

Many of the Chambers of Commerce in smaller cities in the state have far better physician membership than we have in Jefferson County. The efforts and accomplishments toward better living have been and are more effective here than in almost any other community in the state—and a bigger and better program is in the making. We would be wise to bestir ourselves and take a larger share of our responsibility toward this organization.

SAM A. OVERSTREET, M.D.



E. M. Howard, M.D.
1886-1968

E. M. Howard, M.D., Harlan, president of the Kentucky Medical Association in 1942-43, died December 23 at his winter home in Naples, Florida, at the age of 82. A member of one of Kentucky's pioneer families, Doctor Howard was born August 5, 1886, in Harlan. He graduated from the University of Louisville School of Medicine in 1907 and studied surgery in Vienna and Paris. He was a fellow of the American College of Surgeons.

Well known in Harlan County for his 50 years of medical practice and community service, Doctor Howard was president of the Harlan County Medical Society and an instrumental force in the establishment of the Appalachian Regional Hospital Association. He held many offices in the Presbyterian Church and belonged to numerous civic organizations including the Kiwanis Club of which he was a charter member and past president.

In addition to the service he rendered to his local community, Doctor Howard gained state-wide recognition not only as president of KMA but also of the State Board of Health for 35 years. Although he rose to these offices a number of years ago, he consistently served organized medicine in many capacities at the local and state levels until his recent retirement. He will long be remembered for his dedication to duty and for his many contributions to Kentucky medicine through a half century of practice and service.

ORGANIZATION SECTION

KAGP Plans 18th Annual Meeting May 6-10 in Louisville

The Kentucky Academy of General Practice will hold its 18th Annual Meeting and scientific session May 6-10 at Convention Center and the Seelbach Hotel, Louisville.



Doctor Keeney

Included among the many prominent guest speakers will be Arthur H. Keeney, M.D., a former Louisville ophthalmologist now serving as ophthalmologist-in-chief at the Wills Eye Hospital, Philadelphia, Pa. Doctor Keeney will discuss dyslexia and ocular diagnosis in the general practice of medicine. While practicing in Louisville, Doctor Keeney was active in KMA committee work and served on the *Journal's* Board of Consultants. He is now professor and chairman of the department of ophthalmology at Temple University School of Medicine.

Some of the topics to be discussed during the three-day session will include bleeding disorders, immunization therapy, coronary artery disease, pulmonary embolism, pneumonoconiosis and genitourinary malignancies. Guest speakers from throughout the country will participate.

The May 6 luncheon session will feature a talk by Doctor William Ekstrom, vice-president for academic affairs at the University of Louisville. On the evening of May 8 officers will be installed and awards presented at the annual banquet.

Mr. Handley, Guest of Surgeons To Speak at UL Symposium

A symposium on "The Treatment of Early Operable Breast Cancer" at the University of Louisville School of Medicine May 12 will feature as one of its prominent participants Richard Handley, O.B.E., F.R.C.S., London, England, according to George B. Sanders, M.D., Louisville, clinical professor of surgery at the University.

Mr. Handley, chief of breast service at the Middlesex Hospital, will also be a featured guest speaker at the joint meeting of the Kentucky Chapter, American College of Surgeons and the Kentucky Surgical Society the following week. (See story this page.) A 1933 graduate of Cambridge University, Mr. Handley is a member of the Royal College of Surgeons of England and former chairman of its Court of Examiners.

Other guest speakers on the program will include Edward Lewison, M.D., chief, breast service, Johns Hopkins Hospital; Harvey R. Butcher, M.D., St. Louis, Mo.; Bernard Fisher, M.D., Pittsburgh, Pa.; Brian MacMahon, M.D., Harvard Medical School; and William Shelley, M.D., Johns Hopkins University.

All Kentucky physicians are invited to attend the symposium, Doctor Sanders said.

Surgeons To Hold Joint Mtg. May 16-17 in Somerset

The Kentucky Chapter, American College of Surgeons and the Kentucky Surgical Society will meet jointly May 17 at the Holiday Inn, Somerset, according to Sam Weakley, M.D., Louisville, and John Sprague, M.D., Lexington, respective secretary-treasurers of the two organizations.



Mr. Handley

Richard Handley, O.B.E., F.R.C.S., senior surgeon at the Middlesex Hospital, London, England, guest speaker for the session, will discuss "Further Aspects of Breast Carcinoma." This talk will be a continuation of Mr. Handley's discussion of this topic during the University of Louisville's symposium May 12 on "The Treatment of Early Operable Breast Cancer." (See story this page.)

On May 16, preceding the joint session, the Kentucky Surgical Society will have as its guest speaker Max P. Rogers, M.D., Washington, D.C., chief surgeon for the Southern Railway. Doctor Rogers will discuss "Liability and Insurance and Surgery Today." Members of the Society will also participate in the program.

Other speakers and their topics scheduled for the May 17 joint session will include "Tracheal, Bronchial, and Esophageal Foreign Body Extraction," Edwin Nighbert, M.D., and J. Kent Trinkle, M.D., Lexington; "Surgical Problems in Coronary Care,"

C. H. Nicholson, M.D., Lexington; "Injuries of the Inferior Vena Cava in the Diaphragm," W. Burford Davis. M.D. and William T. Rumage, Jr., M.D., Louisville; and "Cryohypophysectomy in Advanced Carcinoma of the Breast," Horace Norrell, M.D., Lexington.

Doctor Weakley and E. Truman Mays, M.D., Louisville, will discuss "Percutaneous Catheterization of the Subclavian Vein in Various Clinical Situations," and William R. Jernigan, M.D., Madisonville, will speak on "Arterial Injuries Due to Blunt Trauma to the Neck." A discussion of "Arterial Embolectomy and Thrombectomy" will be presented by Giles Stephens, M.D., Edward L. Soofield, M.D. and V. Mathur, M.D., Louisville.

Both groups will hold business meetings and elect officers during this spring session.

Ky. Chapter Pediatricians Plan 11th Annual Spring Meeting

The 11th Annual Spring Meeting of the Kentucky Chapter, American Academy of Pediatrics will be May 14-15 at the Holiday Inn, Somerset, according to Robert N. McLeod, Jr., M.D., Somerset, program chairman.

Highlights of the meeting will include a panel discussion of "Current Thinking in Pediatric Surgery", a discussion of medical planning in Kentucky by Frank Groschelle, Frankfort, director of area development, and presentations of a variety of topics in the pediatric field.

In addition to Mr. Groschelle, guest speakers will include Floyd W. Denny, Jr., M.D., Chapel Hill, N.C.; Joseph A. Little, M.D., Nashville, Tenn.; and Hugh B. Lynn, M.D., Rochester, Minn. Chapter members participating in the two-day session will be William W. Johnson, M.D., and Bernard J. Schoo, M.D., Louisville; Richard H. Segnitz, M.D. and Warren E. Wheeler, M.D., Lexington.

Annual Immunization Week Set May 4-10 in Kentucky

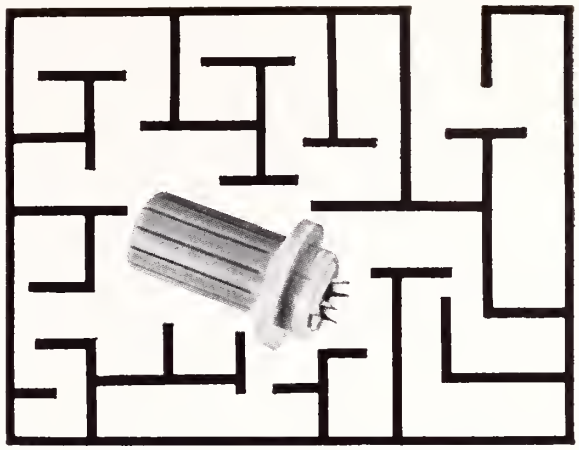
The 1969 Immunization Week in Kentucky will be held May 4-10, according to Ralph Lynn, M.D., Elkton, chairman of the KMA Committee on Community and Rural Health. The committee has completed its plans for observance of the Annual Immunization Week, which includes a request for an official proclamation by Governor Louie B. Nunn. Other state organizations will also join KMA in urging all Kentuckians to check their immunization needs.

Doctor Lynn urges all KMA members and allied groups to take an active part in Immunization Week by displaying special posters promoting this annual drive, and by checking the immunization status of their patients.

"Proper immunization," he noted, "will provide our families with the protection needed from the dreaded diseases of diphtheria, polio, tetanus, pertussis, and smallpox." He stressed that immunization must be a year-round program, and that not only school age children, but also younger children and adults should avail themselves of the vaccines which afford protection against these death dealing diseases.

It was pointed out that proper immunization has resulted in Kentucky's not reporting a new case of poliomyelitis since 1963 when a vigorous vaccine campaign was conducted to rid the state of this killer and crippling disease.

Since Kentucky's Immunization Law was passed, a new, safe, and effective vaccine against measles has been developed. The chairman added that contrary to public opinion, measles can be a serious disease, and he urged that parents also get their children properly immunized against it.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

Board of Health Names Chm.

Sam A. Overstreet, M.D., Louisville, was named chairman of the Kentucky State Board of Health at a February 13 meeting. He is currently serving in the third year of his second term which expires December 31, 1970. A former president of the Kentucky Medical Association, Doctor Overstreet has served on the *Journal* editorial staff for a number of years.

Kentucky TB Organizations Plan Meetings April 23 and 24

A Respiratory Disease Conference for Health Professionals will begin at 10 a.m. April 23 in the Grand Ballroom of the Seelbach Hotel, Louisville, in conjunction with the annual meeting of the Kentucky Hospital Association. The spring scientific session of the Kentucky Thoracic Society and annual meeting of the Kentucky TB and Respiratory Disease Association have been planned the following day at the Mid-Town Holiday Inn, Louisville.

Speakers on the Conference program will include D. Boyd Bigelow, M.D., assistant director of medical services for the Denver, Col. General Hospital; Miss Janet Kerkman, R.N., Colorado General Hospital; William H. Anderson, M.D., Louisville; and Miss Alice Longman, R.N., a member of the Nursing Advisory Service.

The April 24 meeting program will include a discussion of air pollution by John T. Middletown, Commissioner of the National Air Pollution Control Administration, a talk on "Why A National Lung Institute?" by Congressman Tim Lee Carter, M.D., and presentation of a variety of medical topics by Association members.

Kentucky Hospital Association To Meet April 21-24

The 40th Annual Convention of the Kentucky Hospital Association has been planned April 21-24 at the Kentucky Hotel, Louisville. The four-day meeting will include educational sessions, the President's Luncheon and annual banquet, exhibits and meetings of allied groups.

The Wednesday session on Joint Commission Changes will have as panelists Edwin L. Crosby, M.D., director and executive vice president of the American Hospital Association, and George Fahlund, M.D., associate director of the Joint Commission on Accreditation of Hospitals. They will discuss the new standards now being formulated for accreditation.

The Honorable Louie B. Nunn, Governor of Kentucky, will discuss state health care matters at the annual banquet and Ralph Nader, author of "Unsafe at Any Speed", will speak at the President's Luncheon.

Medical Assistants To Meet At Elizabethtown in May

The Seventh Annual Convention of the Kentucky State Association of Medical Assistants, which will include talks by a number of physicians, has been scheduled for May 16-18 at the Holiday Inn, Elizabethtown.

Henry B. Asman, M.D., Louisville, KMA president, will speak at the banquet on the evening of May 17. Speakers and their topics for the educational program Saturday will be "Medical Assistant: Physician: Patient Public Relations," Fred C. Rainey, M.D., Elizabethtown; "Endocrinology," Beverly T. Towery, M.D., Louisville; and "Mentally Retarded Children," Mrs. Amy Zehm, Elizabethtown.

Sunday's program will feature a discussion of "Education through AAMA" by Mrs. Elvira Fischer, Chicago, Ill., past president of the American Association of Medical Assistants. Other program participants will be M. A. Greenwell, M.D., Elizabethtown; M. A. Douglas, M.D., Magnolia; Carson Crabtree, M.D. and Norman Cohen, M.D., Louisville.

Physicians are urged to promote attendance of their assistants at this exciting and informative session.

Psychiatrists To Meet April 24

The theme of the spring meeting of the Kentucky Psychiatric Association April 24 at the Imperial House, Lexington, will be "Community Psychiatry—A Report from Three Community Health Centers", according to Robert Lehman, M.D., Louisville, president.

Arthur Kasey, M.D., Louisville, will serve as moderator for the program. Participants will be Alan Johnson, M.D., Madisonville; John Uzmann, M.D., Glasgow; John Parks, M.D., and Aaron Mason, M.D., Lexington. Robert W. Rasor, M.D., Lexington, will be installed as president during the meeting.

HEW Chiropractic Report Summary Printed for Information

In a recent news release from the American Medical Association, the conclusions of the "Independent Practitioners Study" of chiropractic, conducted by the Department of Health, Education and Welfare by Congressional request, were summarized. The conclusions are reprinted here, as reported by the AMA, for the information of *Journal* readers.

"1. There is a body of basic scientific knowledge related to health, disease, and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.

"2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified.

"3. The inadequacies of chiropractic education, coupled with a theory that de-emphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis and know the

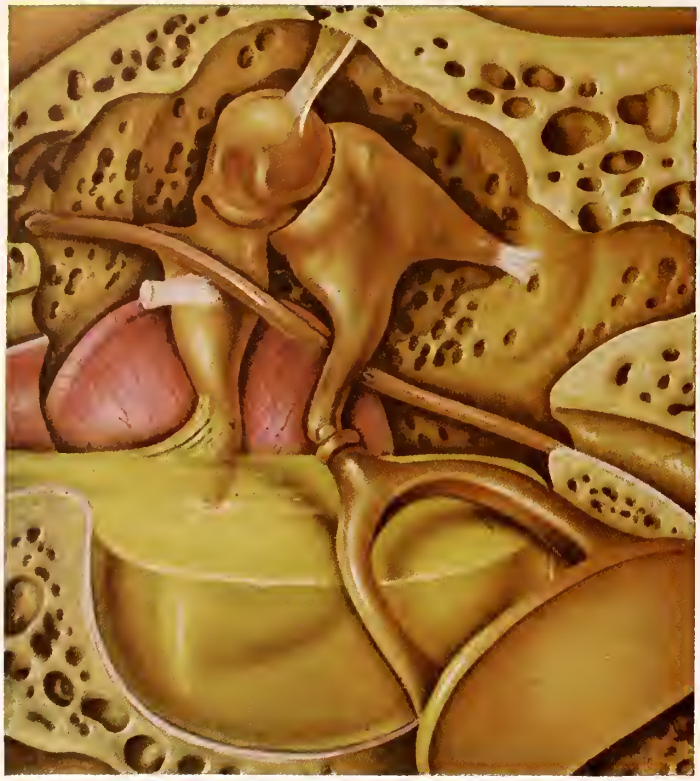
(Continued on page 301)

See next page for prescribing information



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifi in acute otitis medi

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, most common invaders. In otitis media, where is difficult to isolate the causative organism, th coverage may be important. However, some str may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged ac permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enteroc pruritus ani. Skin—maculopapular and erythematous rashes; case of exfoliative dermatitis has been reported. Photosens onycholysis and discoloration of the nails (rare). Kidney—rise in apparently dose-related. Transient increase in urinary output, times accompanied by thirst (rare). Hypersensitivity reactions caria, angioneurotic edema, anaphylaxis. Teeth—dental stainir low-brown) in children of mothers given this drug during the latt of pregnancy, and in children given the drug during the neonata od, infancy and early childhood. Enamel hypoplasia has been s a few children. If adverse reaction or idiosyncrasy occurs, disco medication and institute appropriate therapy. Demethylchlo cycline may form a stable calcium complex in any bone-forming with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. S be given 1 hour before or 2 hours after meals, since absorp impaired by the concomitant administration of high calcium c drugs, foods and some dairy products. Treatment of strepto infections should continue for 10 days, even though symptom subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coate mg, 150 mg and 75 mg of demethylchlo cycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

In the complex picture of moderate to severe anxiety...



There is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

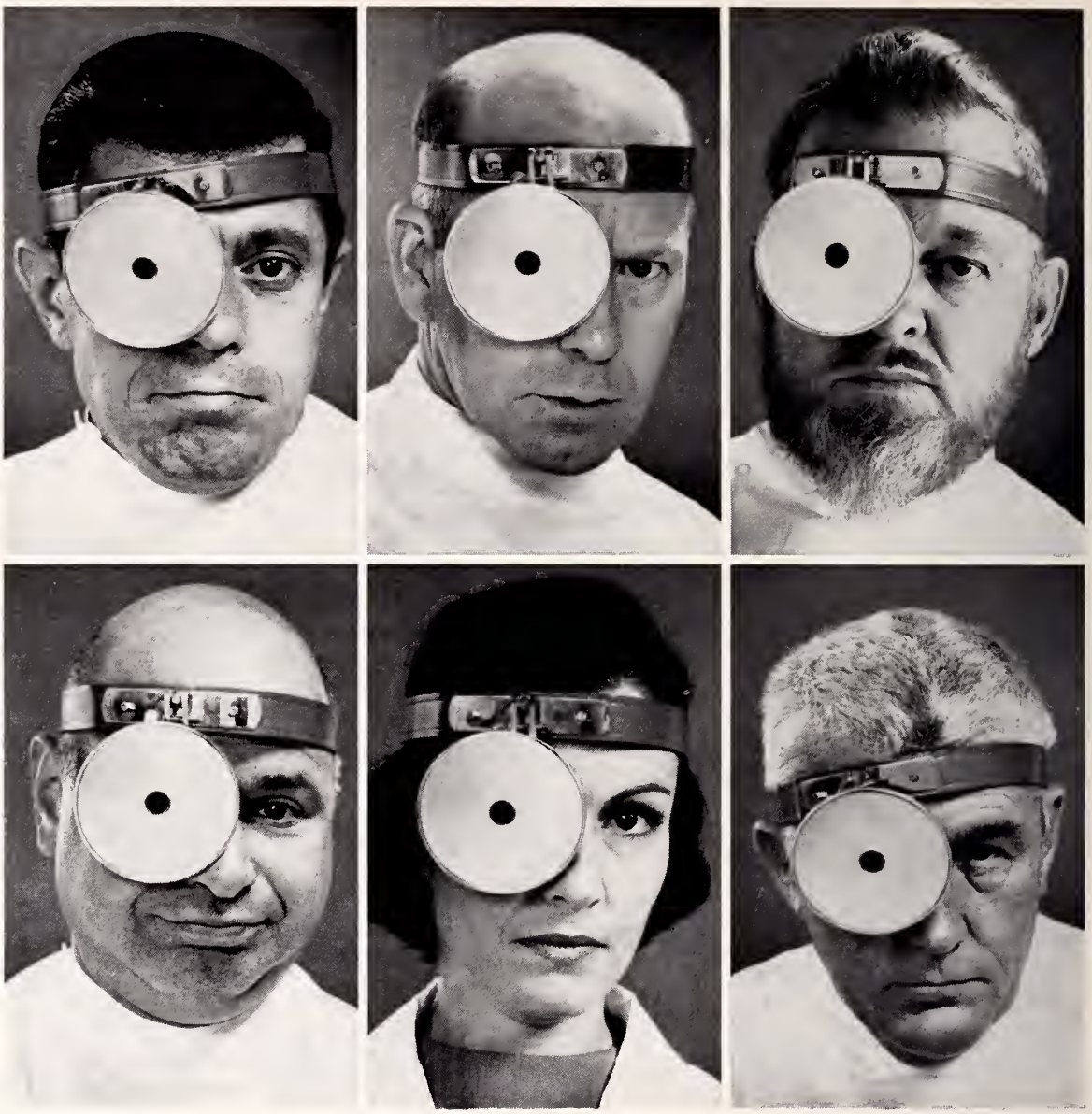
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.



(Continued from page 296)

appropriate treatment, and subsequently provide the indicated treatment or refer the patient. Lack of these capabilities in independent practitioners is undesirable because: appropriate treatment could be delayed or prevented entirely; appropriate treatment might be interrupted or stopped completely; the treatment offered could be contraindicated; all treatments have some risk involved with their administration, and inappropriate treatment exposes the patient to this risk unnecessarily."

The specific HEW recommendation stated:

"Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

In Memoriam

WILLIS B. BLUE, M.D.
Henderson
1921-1969

Willis B. Blue, M.D., 47, a Henderson practitioner for 15 years, died February 10 in an automobile crash. A 1951 graduate of Duke University School of Medicine, Doctor Blue served in the U.S. Navy during World War II and was a member of the Navy Reserve. He was a member of the American Academy of General Practice and the Industrial Medical Association.

W. M. BROWN, M.D.
Corbin
1904-1969

W. M. Brown, M.D., 65, a proctologist, died February 26 at the Southeastern Kentucky Baptist Hospital. Death was attributed to a heart attack. A 1931 graduate of the University of Louisville School of Medicine, Doctor Brown served in the U.S. Navy from 1941 to 1946 when he was discharged as a commander. He was on the Board of Trustees of Cumberland College, Williamsburg.

MAURICE DAVIS, M.D.
Frankfort
1880-1969

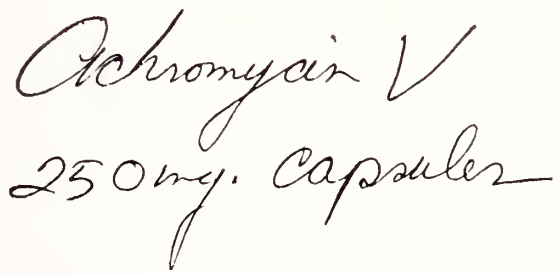
Maurice Davis, M.D., 88, a retired physician who had practiced in Lexington for 40 years, died March 2 at the King's Daughters Hospital. He served as director of the Franklin Health Board for 17 years until his retirement in January. He was a 1903 graduate of the University of Louisville School of Medicine.

BENJAMIN F. SHIELDS, M.D.
Shelbyville
1881-1969

Benjamin F. Shields, M.D., 88, who practiced in Shelby and Spencer counties for more than 50 years, died March 11 at King's Daughters Hospital. A 1905 graduate of the University of Louisville School of Medicine, Doctor Shields was a longtime active member of the Kentucky House of Representatives where he served as speaker in 1940. He retired as a legislator in 1958.

GLENN M. SHIFLEY, M.D.
Paducah
1912-1969

Glenn M. Shifley, M.D., 56, an anesthesiologist, died February 28 at Western Baptist Hospital. Doctor Shifley was a 1941 graduate of the University of Louisville School of Medicine and a member of the National Board of Anesthesiologists. He had practiced in Paducah for seven years.



ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481C-9

KMA Committee Reports

Committee on Cults

David B. Stevens, M.D., Lexington, Chairman

KMA Headquarters Office **February 12, 1969**

The Committee on Cults held its second meeting of the Associational year on February 12, 1969. Guest at this meeting was William J. Brown, Louisville, who holds a Ph.D. degree in audiology. Doctor Brown made an interesting presentation to the Committee.

The members of the Committee discussed the distribution of the recent report to Congress by the Secretary of HEW and the Senior Citizens newspaper article, both of which strongly reject the inclusion of chiropractic treatment under Medicare.

Committee on Appalachian and OEO Programs

Frank M. Gaines, Jr., M.D., Louisville, Chairman

KMA Headquarters Office **February 20, 1969**

The Committee on Appalachian and OEO Programs met on February 20, 1969, with Mary Pauline Fox, M.D., Hyden, and Russell Hall, M.D., Prestonsburg, as guests.

Doctor Fox presented an informative talk on the OEO Programs in the Leslie County area. Doctor Hall spoke to the members on the operation of the OEO Program in the Floyd-Martin County area.

Advisory Committee to Selective Service

Glenn U. Dorroh, M.D., Lexington, Chairman

KMA Headquarters Office **February 26, 1969**

The Advisory Committee to Selective Service met recently together with the State Selective Service Director, Colonel Taylor L. Davidson and his staff.

At this time, the Committee reviewed the 1969 draft call for physicians and made recommendations to the State Headquarters for Selective Service.

Plans and Development Committee

George A. Sehlinger, M.D., Louisville, Chairman

KMA Headquarters Office **March 6, 1969**

The new KMA Plans and Development Committee held its first meeting recently with primary attention given to organizational efforts.

KMA President Henry B. Asman, M.D., outlined some possible Committee activities and the members discussed their duties and plans for the future. The number of Committee members was increased and April 10 was set as the next meeting date.

Hyperadrenalism

(Continued from page 288)

Summary

Hyperadrenalism with its bizarre and subtle manifestations began to be recognized and brought into clinical prominece soon after the turn of the century. Largely on an empirical basis surgical ablation ranging from excision of a single small tumor to total adrenalectomy evolved over the ensuing decades. During this period an ever broadening understanding of the chemical changes involved in the genesis of hyperadrenalism of both cortical and medullary origin has taken place. In recent years temporary control of several of these pathological states has been effected by using chemical antagonists to block the production of specific substances being elaborated in abnormal amounts or neutralize their effect on the way to the site of their deleterious action. This trend justifies the anticipation and hope that surgical measures in the future may not be necessary.

References

1. Cannon, W. B.: *Bodily Changes in Pain, Hunger, Fear and Rage.* Charles T. Branford Co. Boston, 1953 (Second Edition) p. vi, vii (Preface to First Edition).

2. Dorfman, R.I. and Ungar, F.: *Metabolism of Steroid Hormones.* Academic Press, New York, 1965.

3. Yates, F.E. and Urquhart, J.: Control of plasma concentrations of adrenocortical hormones. *Physiol. Rev.* 42:359, 1962.

4. Ney, R. L., Shimizu, N., Nicholson, W. E., Island, D. P. and Liddle, G. W: Correlation of plasma ACTH concentration with adrenocortical response in normal human subjects, surgical patients, and patients with Cushing's disease. *J. Clin. Invest.* 42:1669, 1963.

5. Tait, J. F. and Burstein, S.: In vivo studies of steroid dynamics in man in *The Hormones* Academic Press, New York, 1964, Vol. V, pp. 441-557.

6. Jones, K. M., Lloyd-Jones, R., Riondel, A., Tait, J. F., Tait, J. F., Tait, S.A.S., Bulbrook, R. D. and Greenwood, F. C.: Aldosterone secretion and metabolism in normal men and women and in pregnancy. *Acta. Endocr.* 30:321, 1959.

7. Childs, B., Grumbach, M. M. and Van Wyck, J. J.: Virilizing adrenal hyperplasia: A genetic and hormonal study. *J. Clin. Invest.* 35:213, 1956.

8. Goodall, McC.: Studies on noradrenaline and adrenaline in mammalian heart. *Acta. Physiol. Scand.* 24 (Suppl 85): 1-51, 1951.

9. Rosenfeld, G., Leeper, L. C. and Udenfriend, S.: Biosynthesis of norepinephrine and epinephrine by the isolated perfused calf adrenal. *Arch Biochem.* 74:252, 1958.

10. Graham, J. B.: Pheochromocytoma and hypertension: An analysis of 207 cases. *Int. Abstr. Surg.* 92:105, 1951.

11. Cushing, H.: *The Pituitary Body and Its Disorders.* J. B. Lippincott Co., Phila., 1912.

12. Conn, J. W., Knopf, R. F. and Nesbit, R. M.: Clinical characteristics of primary aldosteronism from analysis of 145 cases. *Amer. J. Surg.* 107:159, 1964.

13. Gabrilove, J. L., Sharma, D. C., Wotiz, H. H. and Dorfman, R. I.: Feminizing adrenocortical tumors in the male: A review of 52 cases including a case report. *Medicine* 44:37, 1965.

Medical Economics says:

GENERAL LEASING'S PLAN IS

"The Winning Way"

TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

s grateful for this tribute to its "Doctor's .ease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter n "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- Leasing better than buying
- No capital investment
- Dependable car at all times
- Certain tax advantages
- Call us for particulars

LEASE
Medical or Surgical
EQUIPMENT

- ★ A plan for young doctors
- ★ Medical and Surgical equipment
- ★ Complete office furnishings
- ★ Enlarging facilities
- ★ Call us for full details

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207

BRONCHIAL DISTRESS

mudrane®

Emphysema, Chronic Bronchitis and Asthma are relieved in fifteen minutes by the fast-disintegrating, uncoated Mudrane tablet.

Checkpoints:

DILATES THE BRONCHI
DRAINS THE MUCUS
SEDATES MILDLY
SUSTAINED ACTION
SUPERIOR TOLERANCE

Each tablet contains:

POTASSIUM IODIDE	195 mg.
AMINOPHYLLINE	130 mg.
PHENOBARBITAL, Caution: may be habit forming.	21 mg.
EPHEDRINE HCl	16 mg.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop. Iodide contraindications: tuberculosis, pregnancy.

DOSAGE: One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

mudrane®

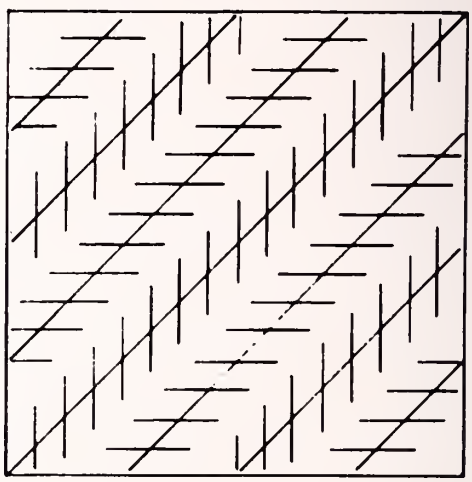
BRONCHIAL DISTRESS

—The lowest priced tetracycline—nystatin combination available—



OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, c tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, opera machinery, driving). Though physical and p chological dependence have rarely been repo on recommended doses, use caution in ministering Librium (chlordiazepoxide hy chloride) to known addiction-prone individ or those who might increase dosage; withdra symptoms (including convulsions), follow discontinuation of the drug and similar to th seen with barbiturates, have been reported. of any drug in pregnancy, lactation, or in wor of childbearing age requires that its poter benefits be weighed against its possible haza As with all anticholinergic drugs, an inhibi effect on lactation may occur.

PRECAUTIONS: In elderly and debilita limit dosage to smallest effective amount to clude development of ataxia, oversedation confusion (not more than two capsules per initially; increase gradually as needed and tc

or here.



). Though generally not recommended, if bination therapy with other psychotropics is indicated, carefully consider individual macologic effects, particularly in use of potiating drugs such as MAO inhibitors and nothiazines. Observe usual precautions in ence of impaired renal or hepatic function. adoxical reactions (*e.g.*, excitement, stimulaand acute rage) have been reported in psytric patients. Employ usual precautions in tment of anxiety states with evidence of imding depression; suicidal tendencies may be ent and protective measures necessary. Vari- effects on blood coagulation have been orted very rarely in patients receiving the and oral anticoagulants; causal relation- has not been established clinically.

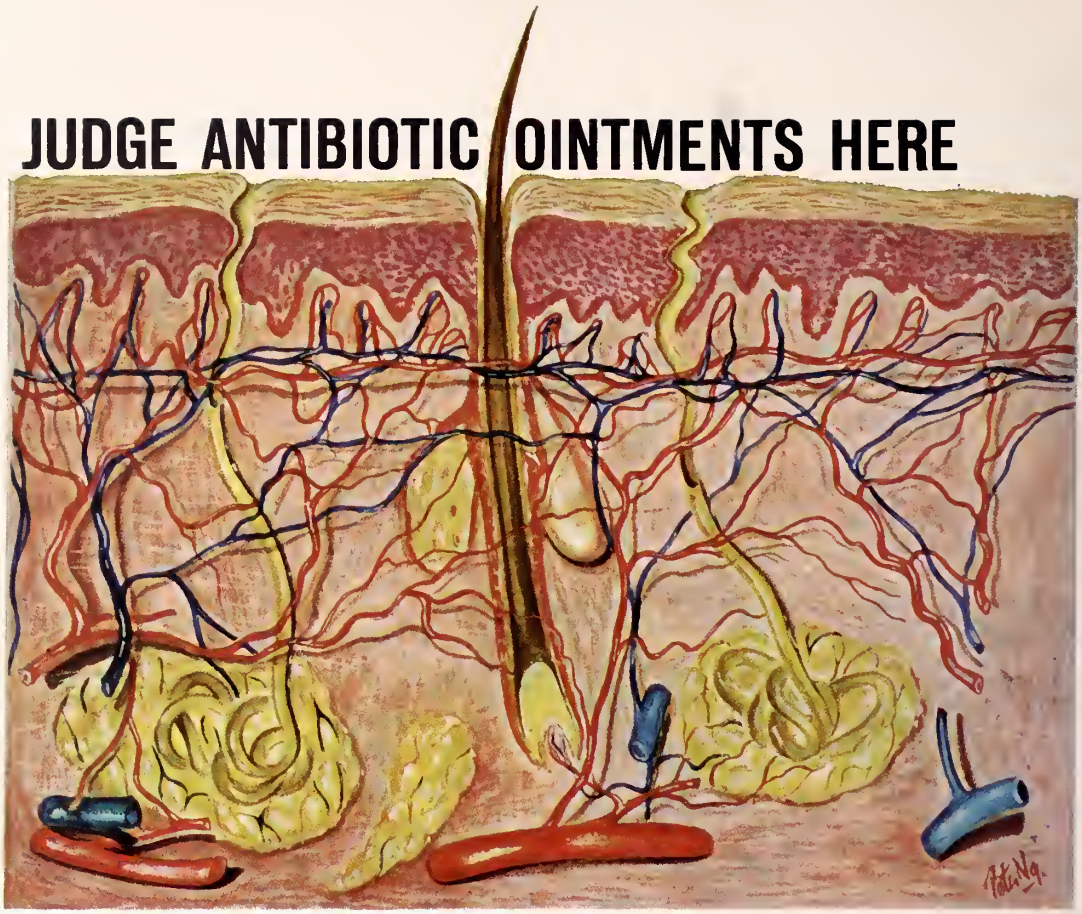
DVERSE REACTIONS: No side effects or nifestations not seen with either compound ie have been reported with Librax. When rdiazepoxide hydrochloride is used alone, wsiness, ataxia and confusion may occur, cially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

(Continued from page 267)

2. Stamler, J. et al: Coronary risk factors, their impact and their therapy in the prevention of coronary heart disease. *M. Clin. North America* 50: 229-254, 1966.
3. Page, I.H. and Stamler, J.: Diet and coronary heart disease. *Modern Concepts of Cardiovascular Disease*. 37: 119-128, 1968.
4. Best, M.M. and Duncan, C.H.: Effects of cholesterol lowering drugs on serum triglycerides. *J.A.M.A.* 187: 37-40, 1964.
5. Schaefer, L.E. Hyperlipidemia. *Ann N.Y. Acad. Sci.* 148 925-936, 1968.
6. Horton, E.S., Sheikholislam, B.M., and Bressler, R.: Combined sulfonylurea phenformin therapy of the dyinsulinism of early diabetes mellitus. *Ann. N.Y. Acad. Sci.* 148: 778-786, 1968.
7. Best, M.M. and Duncan, C.H.: Effects of clofibrate and dextrothyroxine singly and in combination on serum lipids. *Arch. Int. Med.* 118: 97-102, 1966.
8. Fallon, H.J. and Woods, J.W.: Response of hyperlipoproteinemia to cholestyramine resin. *J.A.M.A.* 204: 1161-1164, 1968.

County Society Reports

McCRACKEN

The regular monthly meeting of the McCracken County Medical Society was held February 26 at Boswell's Restaurant, Paducah. Paul E. Davis, M.D. and John C. Burris, M.D. were accepted into the Society's membership.

The members discussed the formation of a Peer Committee to review complaints of overcharging by insurance carriers and appointed the Grievance Committee to act as this group.

A scientific discussion of conservative management of acute and chronic renal failure was presented by Daniel Leb, M.D., Louisville, associate professor of medicine at the University of Louisville, who showed slides illustrating dialysis methods.

Class Size Increased at UK

In an effort to increase health manpower and improve admission opportunities the University of Kentucky College of Medicine will increase the size of its entering classes by 10 percent in the fall. The faculty agreed to increase the present figure of 80 to 88, which is the maximum number that can be accommodated with existing facilities, according to William S. Jordan, M.D., dean of the College.

Services Catalog Offered

Smith Kline & French Laboratories recently released a new edition of its *SK&F Services Catalog* (69/70) which is available free of charge to physicians. Included in the booklet are medical films, periodicals, Speakers Bureau and similar services. The catalog may be obtained from Services Dept. E-10, Smith Kline & French Laboratories, 1500 Spring Garden St., Philadelphia, Pa. 19101.

AMDOC Adds Team Service

AMDOC, an independent voluntary agency which places physicians in critical areas throughout the world, has initiated a new team placement program for both physicians and medical students. Information about this program, entitled Foreign Service Team Preceptorship, may be obtained from AMDOC, Inc., 27 E. Canon Perdido St., Santa Barbara, Calif. 93101.

UK Adds New Graduate Program

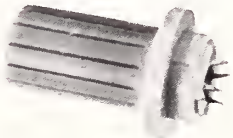
Joseph V. Swintosky, dean of the University of Kentucky College of Pharmacy, has announced a new graduate program in Pharmaceutical Sciences which will lead to Master of Science and Doctor of Philosophy degrees. Dean Swintosky noted that students in the program will be provided with instruction from the College of Pharmacy and research opportunities at the Medical Center.

ACS Director-Elect Named

The American College of Surgeons has named as its director-elect C. Rollins Hanlon, M.D., professor of surgery and chairman of the department at St. Louis University School of Medicine, according to a recent press release. Doctor Hanlon will assume the directorship soon after the close of the College's Clinical Congress in October. He succeeds John Paul North, M.D., who is retiring from the position.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

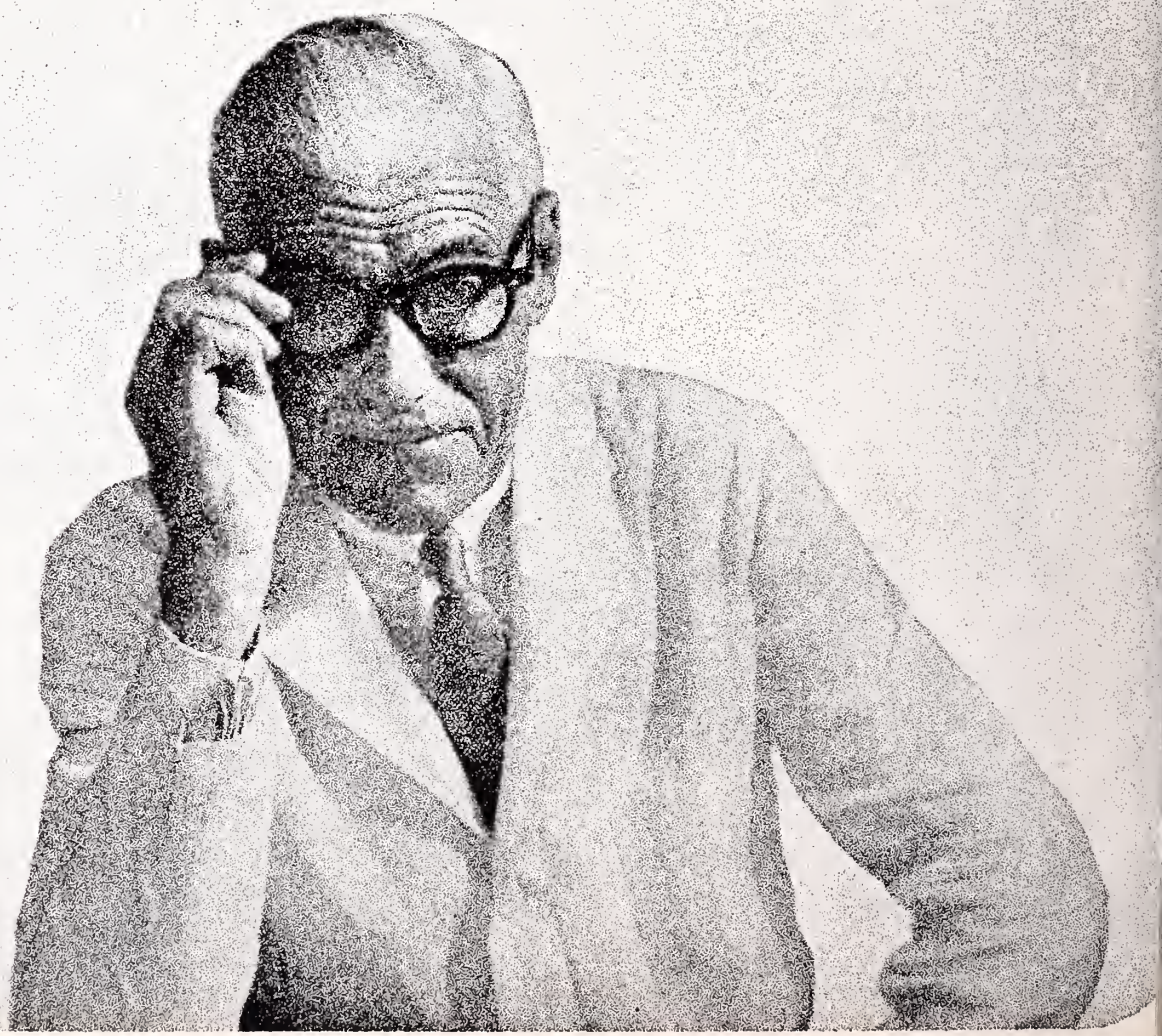
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-253-2761

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665 President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660 Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123 Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661 Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211 Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282 Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 .. Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 .. Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362 .. 1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525 .. 1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231 1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406 1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751 1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155 1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616 .. 1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357 1969

Buyers Guide

APRIL BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Cancer Society 310
American Medical Association 2SS

Blue Cross-Blue Shield 241
Bristol Laboratories 243
Burroughs Wellcome 308

Geigy Pharmaceuticals 2S2-2S4
General Leasing Carporation 303
Glenbrook Laboratories 300

Highland Hospital 311
Hynsan, Westcott & Dunning 237

Kentucky Thoracic Society 2S1

Lederle Laboratories 239, 29S, 297-298, 301, 304, 309
Lilly, Eli & Company 268

Medical Protective Company 311
Mid-South Medical Association 249

Parke, Davis Company 2S7
Pitman-Moore Company 260-261
Poythress, Wm. P. Company 303

Rabins, A. H. Company 24S-246, 263, 30S
Roche Laboratories 264-26S, 306-307

Sandoz 299
Searle, G. D. & Company 278-279
Southern Optical Company 304
Strasenburgh Laboratories 280
Stuart Company 236

Warner-Chilcott 247-248
Winthrop Laboratories 277
Wyeth Laboratories 2S8-2S9, 313



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal
(persistent palpitations)



Valium®
(diazepam)

for reliable relief of psychic tension and associated somatic and depressive symptoms (including tension-induced insomnia)... usually well tolerated... 2-mg, 5-mg or 10-mg tablets *t.i.d.* and *h.s.*

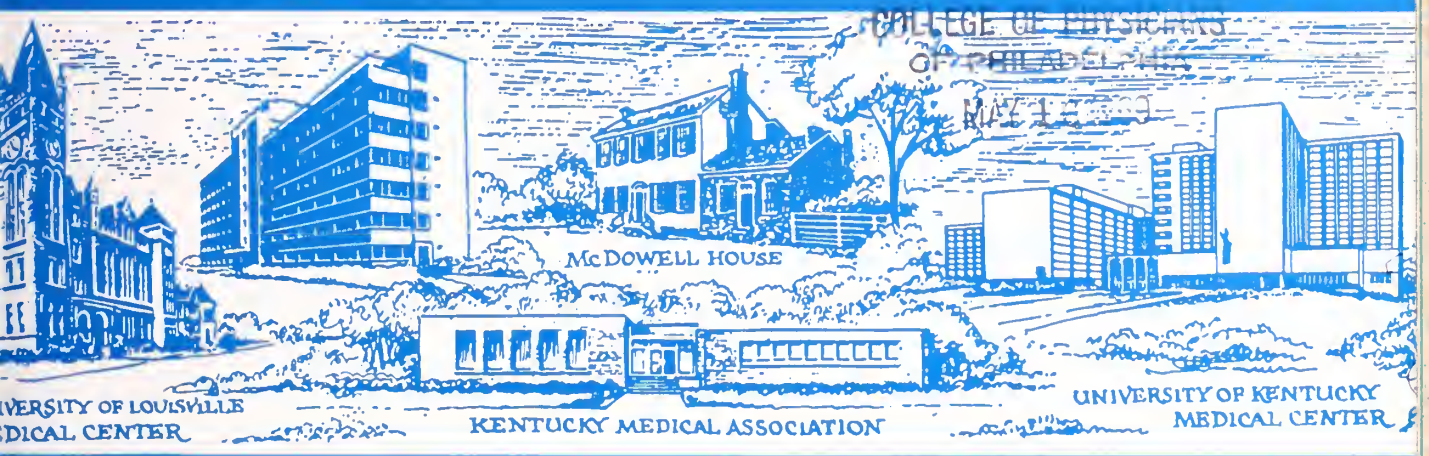
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

VOLUME 67 MAY 1969 NUMBER 5

The Journal of The KENTUCKY Medical Association

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAY 12 1969



In This Issue

Regional Enteritis and Chronic Ulcerative Colitis
Coleman C. Johnston, M.D., F.A.C.S. 343

Primary Inguinal Hernia Repair
Romeo S. Berardi, M.D. 350

What's New in Prosthetic Heart Valves
J. Kent Trinkle, M.D., F.A.C.S. and Lester R. Bryant, M.D., F.A.C.S. 352

Special Article

Blue Shield's Partnership with Medicine
George Dunlop, M.D. 362

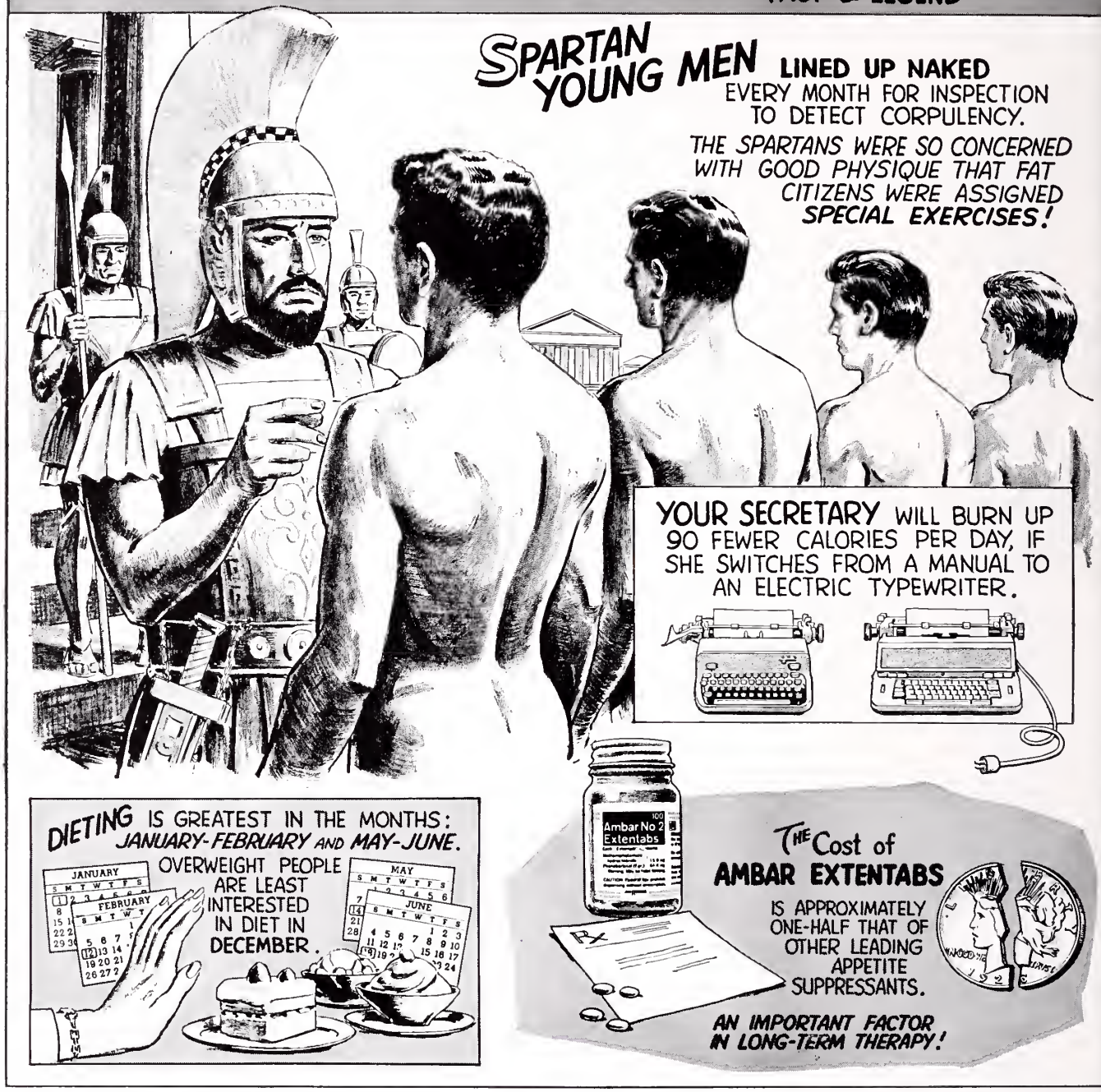
Complete Contents on page 318

KMA 1969 Annual Meeting — September 23-25
Convention Center, Louisville

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAY 1 6 1969

Lutrexin®

HW&D BRAND OF LUTUTRIN

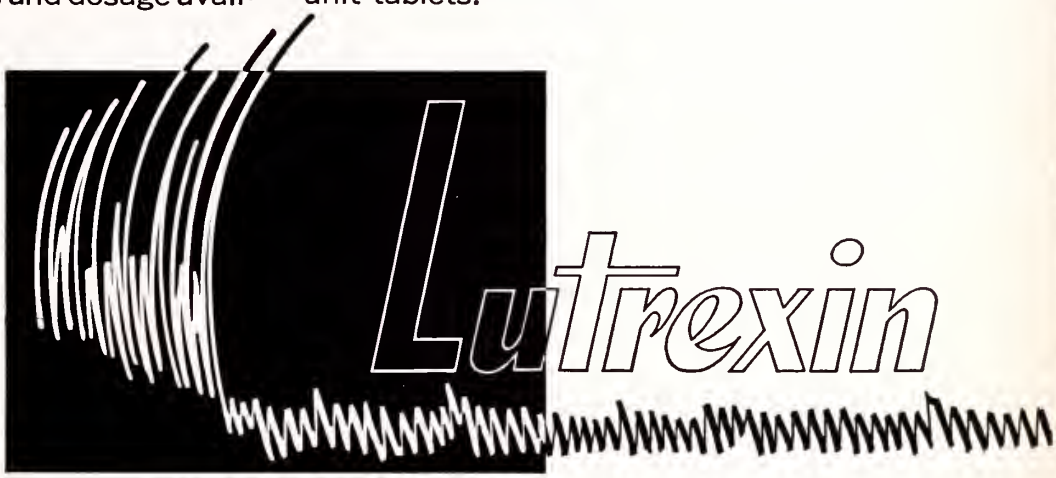
3000 UNIT TABLETS

I THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

LUTREXIN, the non-steroid "uterine laxing factor" has been found to be useful many clinicians in controlling abnormal erine activity.

Literature on indications and dosage avail-ble on request.

- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

Volume 67 • May 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Cae, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Rabert G. Cax

• ASST. MANAGING EDITOR
Peggy Roberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussions
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1971

McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Raddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970

Douglas L. Athertan, M.D.
Keith M. Caverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D
Ray A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
Iahn H. Willard, M.D.

Term Expires July 1, 1969

Poul E. Lett, M.D.
David A. Orrihood, M.D.
Harry A. Homiltan, Jr., M.D.
Leslie W. Blokey, M.D.
Raymond J. Timmermon, M.D
Williom H. Gillespie, M.D.
J. J. Sonne, M.D.
John L. Creech, Jr., M.D

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Regional Enteritis and Chronic Ulcerative Colitis
Coleman C. Johnston, M.D., F.A.C.S. 343

Primary Inguinal Hernia Repair
Romeo S. Berardi, M.D. 350

What's New in Prosthetic Heart Valves
J. Kent Trinkle, M.D., F.A.C.S. and Lester R. Bryant, M.D., F.A.C.S. 352

SPECIAL ARTICLES

Blue Shield's Partnership with Medicine
George Dunlop, M.D. 362

EDITORIALS

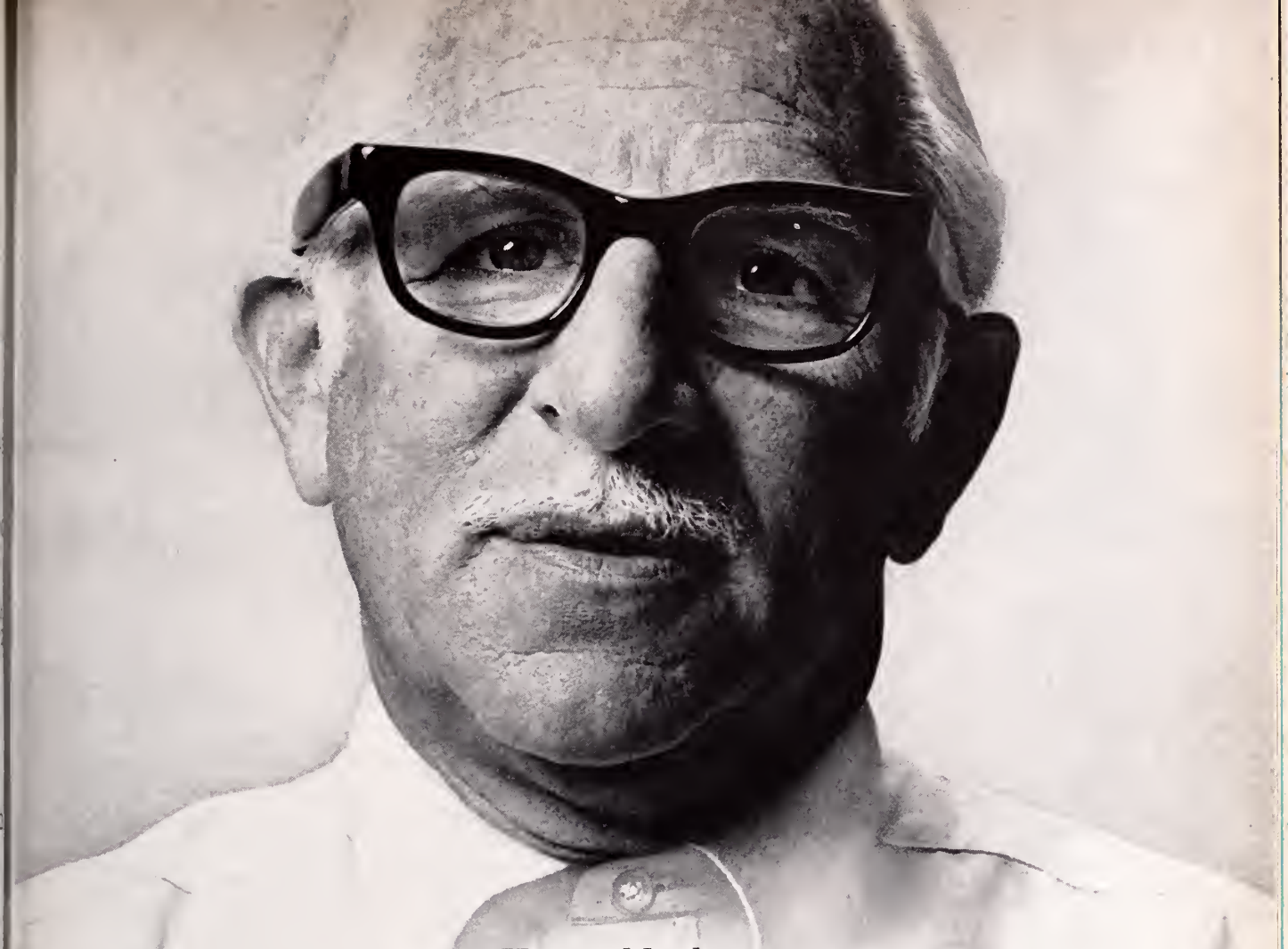
Learning Centers
Walter S. Coe, M.D. 365

ORGANIZATION SECTION

Distinguished Guest Speakers To Appear on Scientific Program of KMA Annual Meeting September 23-25 in Louisville 366
Seven Trustee Districts To Meet During May and June 366
AMA To Hold 118th Convention in New York July 13-17 367
Mr. Spangler Named To Head Ky. Public Health Assn. 367
Ky. Dentists Name Dr. Logan President-Elect at Meeting 367
Record Attendance Reported at 1969 Interim Meeting 368
Digest of Proceedings, Board of Trustees, March 26, 1969 374
Fifty-Seven Physicians Attend Spring Orientation Program 374

REGULAR FEATURES

President's Page 320
Maternal Mortality Page 322
Blue Shield Page 331
Public Health Page 332
Postgraduate Opportunities 338



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



Planning Ahead

AN ADDITION to KMA's organizational structure has recently been made in the appointment of the Committee on Plans and Development as one of the permanent committees of the Association.

It is envisioned that this committee will contribute mightily to the continued growth and vitality of the Association in the years ahead. It is, perhaps, an outgrowth of the "Hoover Commission" which, in its report to the Board of Trustees two years ago, made the following observation: "Our study has been only a beginning of what should be a continuous self-study to ensure that Kentucky Medicine will provide the leadership to its members, to the government, and to the people of this Commonwealth, not only in matters related to health, but in community affairs, in the development of the resources of our State, and in any endeavor which will make Kentucky a better place in which to live".

The Committee on Plans and Development has representation from academic medicine, industrial medicine, the younger physicians in private practice, and from SAMA (two students are non-voting members), as well as from the older group of physicians who are better acquainted with organized medicine in Kentucky. George Sehlinger, M.D., Fifth District trustee, is chairman.

You may be assured that this committee will welcome suggestions and comments from any member of this Association, in writing or in person. The date of its next meeting may be obtained from the Headquarters Office.

Henry B. Asman

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens...and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F, 5—2/23/67. For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

Case 15-67. A 21 year old white primigravida whose last normal menstrual period had begun on July 28, 1967 presented at 3:30 a.m. on October 10, 1967, at the emergency room with the history of submitting to an attempted criminal abortion on the morning of October 6, 1967. She stated that on October 9, 1967, she removed a vaginal pack and that afternoon at about 3 p.m. she began having fever and chills. There had been no bleeding or cramping. The past medical history and family history were not remarkable. On examination on October 10, 1967, the blood pressure was 110/70, temperature 103.8°. The lungs were clear, the heart was normal, and the abdomen was soft but tender in both lower quadrants with normal bowel sounds. There was no rebound or rigidity. On pelvic examination, the uterus was enlarged to the size of a six to eight weeks' gestation. A rubber catheter was removed from the closed cervical os. There was no bleeding from the uterus. The adnexa were normal. The remaining physical examination was normal. Cultures were taken from the cervical os; two blood cultures were obtained. Intravenous fluids were begun in the emergency room with the addition of aqueous penicillin and chloromycetin to the intravenous infusion. The patient was transferred to the ward. The hemoglobin was 10.8 grams percent, hematocrit 30, and white blood count 5,000 with 99 percent polymorphonuclear leukocytes.

On the ward, at 4:50 a.m. the temperature was 103°, pulse 110 and blood pressure 110/70. The intravenous fluids with antibiotics were running. At 7:20 a.m. her temperature was 106°, pulse 140 and blood pressure 110/70. The patient was delirious and quite restless. Iced alcohol sponging was begun and a Foley catheter inserted. The rate of intravenous infusion was increased. The urine output was approximately 220-250 cc. The iced alcohol sponging was continued until 9:30 a.m. with the temperature remaining at 104.8° by rectal telethermometer. The pulse and blood pressure were steady as before and the urinary output remained consistently over 100 cc per hour. A white blood count drawn at 8 a.m. was reported as 1500 cells per cubic mm. A unit of whole blood was administered and the patient was transferred to the intensive care unit with a temperature of 104°.

There, a subclavian catheter was inserted to monitor the central venous pressure. At 10 a.m. the pulse was 124, blood pressure 110/20, temperature 102° and central venous pressure 13 cm. The urinary output remained greater than 100 cc; a total of 500 cc had been put out since admission. At 10:10 a.m., the blood pressure dropped to 90 systolic; 500 mg. of Solucortef was given, followed by a second 500 mg 20 minutes later. The central venous pressure remained steady at 10-13 cm and the blood pressure rose to 110/70; the pulse was 120 and the temperature, 101.2°. At 11 a.m. the intravenous fluid administered totaled: 2500 cc., plus 500 cc of whole blood. The antibiotics totaled: aqueous penicillin, 30,000,000 units and Chloromycetin, 5 grams. The urinary output was good. One gram of Kanamycin was administered intramuscularly. Blood gases and pH were drawn along with electrolytes. Her vital signs stabilized: pulse 110 to 120, blood pressure 110/70, temperature 101.2°, and the central venous pressure 13-16 cm. A D & C was planned immediately. Between 11 a.m. to 12 p.m. the urinary output ceased, suddenly and entirely. Her color was cyanotic with poor peripheral capillary filling. The pulse was 120-140, systolic blood pressure 90 to 100 and temperature 101°. The central venous pressure had risen to 21 cm. Generalized convulsions began. Laboratory reports were as follows: white blood count 4,567 with adequate platelets, arterial gases pO_2 12.8, and chlorides 109 mEq/1.

At 12:30 p.m. she was taken to the operating room and at 1 p.m. an endotracheal intubation was performed. Under light general anesthesia bimanual examination confirmed the size of the uterus at six to eight weeks. Cervical dilatation was then performed and ring forceps curettage produced a small amount of necrotic placental tissue. The estimated blood loss was 200 cc. The patient tolerated the procedure rather poorly and was taken to the intensive care unit at 1:30 p.m. Her color remained ashen and generalized convulsions persisted on an intermittent basis. Fluids were administered more cautiously since the venous pressure had risen to 21 cm. Solucortef was again administered and nasal O_2 was begun. Antibiotics in: at 1:30 p.m. Kantrex 1 gram, penicillin 60,000,000 units, chloromycetin 6.5 grams, Solucortef 2 grams. Small doses of Amytal in the order of 100 to 200 mg. had been given intermittently to diminish convulsions. She was digitalized.

In the intensive care unit at 1:30 p.m. the pulse was 140, blood pressure 110/70, CVP 21 and urinary output 0. Her color was ashen and there were

continual jerking movements of all extremities. Electrolytes and CBC determination were repeated. Blood continued to ooze from the needle puncture sites as well as vaginally. She remained unresponsive and the pupils were widely dilated. At 2:15 p.m. the central venous pressure was back to 5-6 cm., the blood pressure was 100/70, pulse 140 and urinary output 0. She continued to be unresponsive. The intravenous infusion rate was increased in view of the central venous pressure. Whole blood, 500 cc, was also given. Moderate bleeding continued. Blood was again drawn at 3 p.m. for blood gas and pH determinations, type and crossmatch and fibrindex. She was markedly acidotic; pH 7.18, pO_2 81, pCO_2 30.7 (arterial), hemoglobin 11.6, hematocrit 34, white blood count 20,400 with 65 percent stabs and no platelets in the peripheral smear. The fibrindex was reported as subnormal. Following this time, the patient's condition continued to deteriorate and a tracheostomy was performed at 4:15 p.m. to facilitate clearing of secretions; she was connected to an air shields respirator. The pulse was 100, blood pressure 115/70, temperature 98.4° and urinary output 0. Solucortef 1 gram was given, and fibrinogen, 2 grams, was given at 5:45 p.m. and again at 6 p.m., together with 5 grams of Amicar. Her convulsions persisted, despite amytal. Her vital signs began to fall and she expired at 6:40 p.m. Resuscitation attempts failed and she was taken to the morgue. Permission for autopsy was obtained.

The principal findings were: septic abortion, tracheostomy, congestion and edema fluid in the trachea, bilateral hydrothorax, 1000 cc; acute pulmonary congestion and edema; septic splenitis; hemoperitoneum, 700 cc; hemorrhagic right corpus luteum cyst with tear; hemorrhage in the pelvis of the kidney; hemorrhagic cystitis, cervical laceration (vaginal surface), hemorrhage into adrenal glands bilaterally, post D & C endometrium and uterine fibroid. The cause of death was overwhelming infection with septic shock following criminal abortion.

Comments

The Committee considered this a direct obstetric death with preventable factors attributable to the patient and her family. Despite the availability of highly specialized modern intensive care facilities, the patient developed septic shock following the establishment of a virulent infection associated with a grossly contaminated criminal abortion. Infection continues to represent one of the three principal causes of obstetric death in spite of modern medical advances.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G.I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

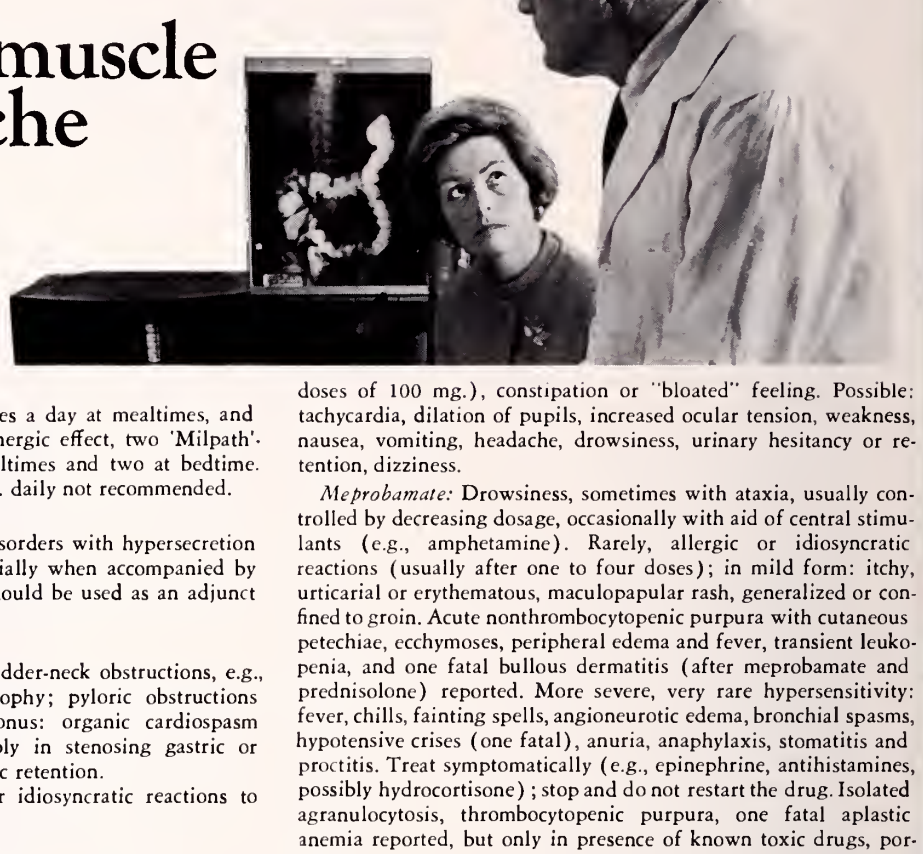
relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:
'Milpath'-400: Yellow, scored tablets.
'Milpath'-200: Yellow, coated tablets.
Before prescribing, consult package circular.

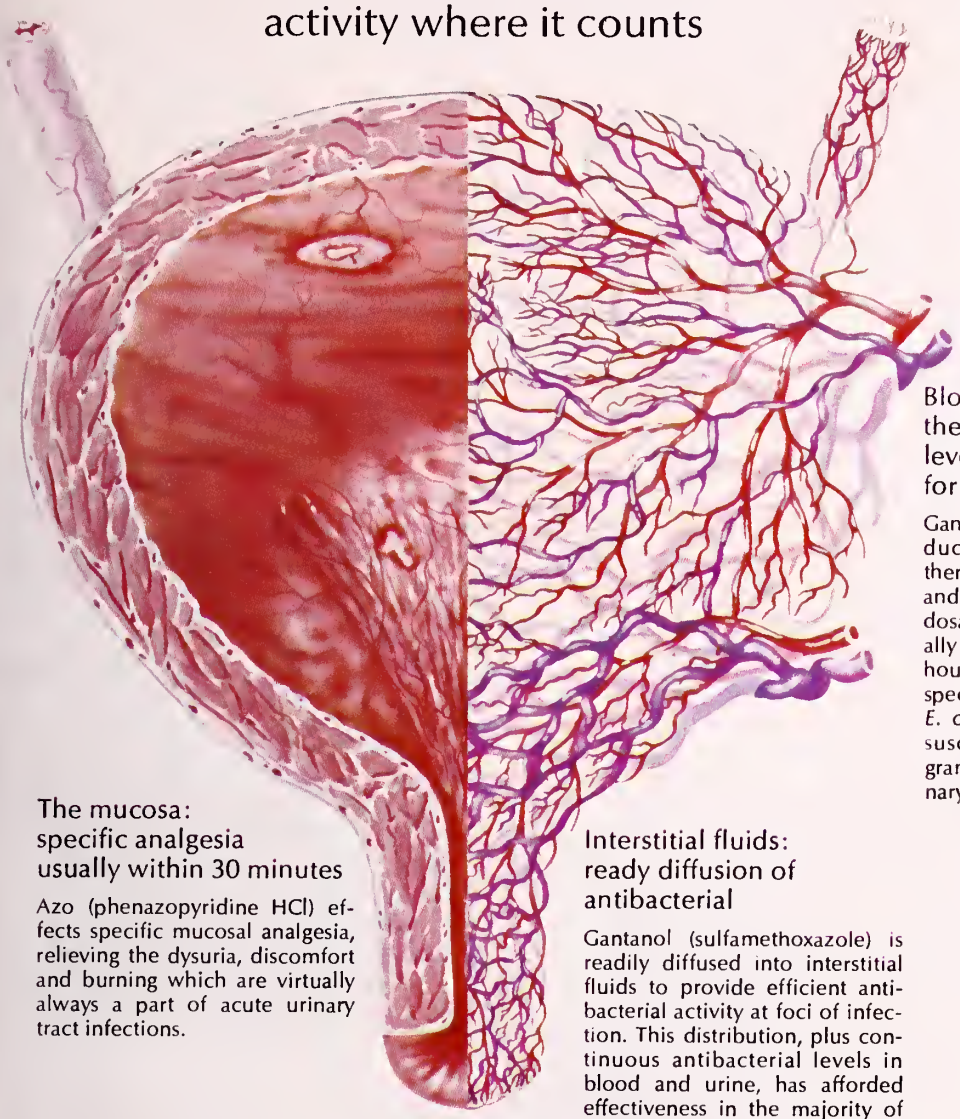
References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



The mucosa: specific analgesia usually within 30 minutes

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Interstitial fluids: ready diffusion of antibacterial

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient *b.i.d.* dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes *E. coli* and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

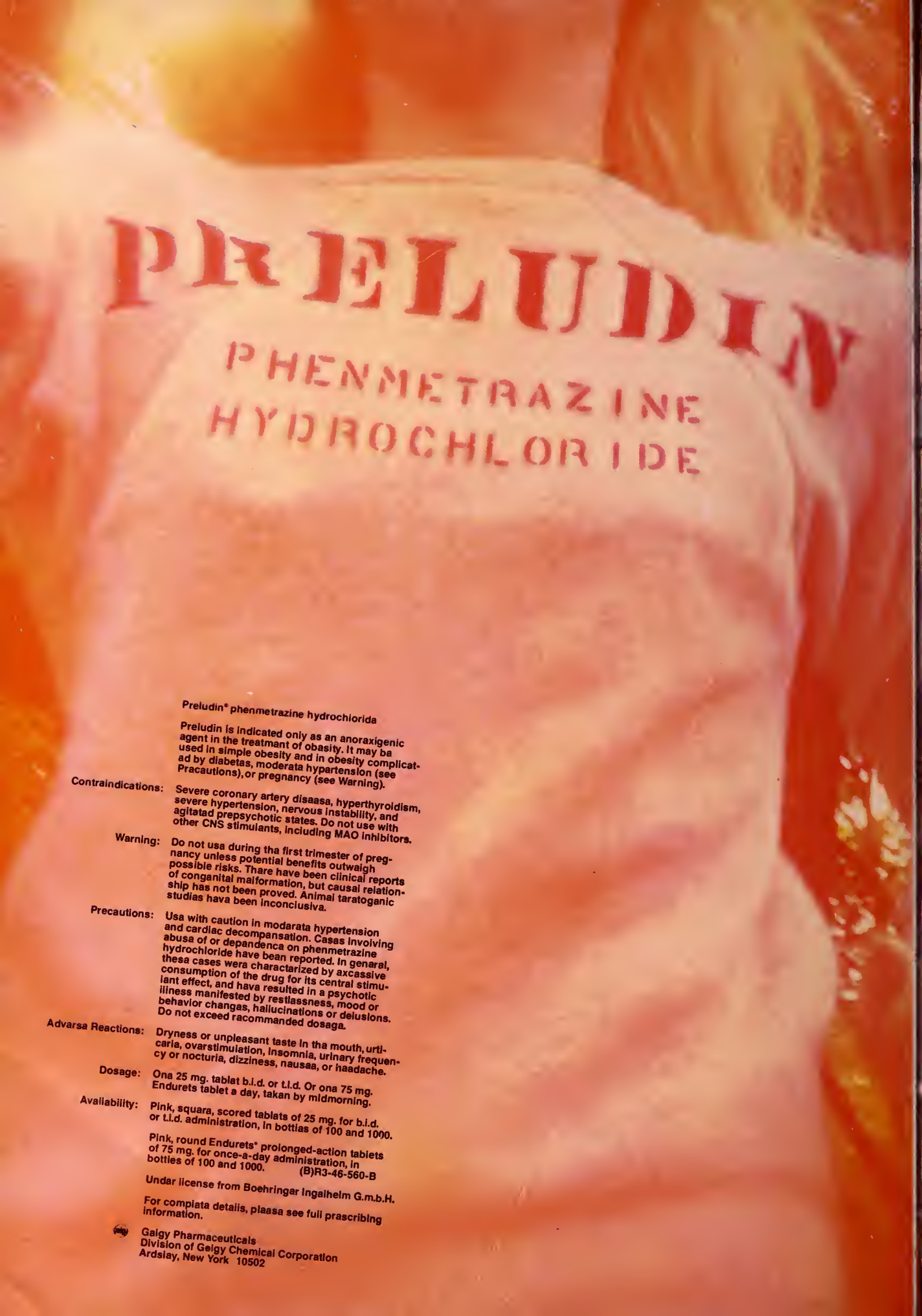
ROCHE

Roche LABORATORIES

Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)



Preludin® phenmetrazine hydrochloride

Preludin is indicated only as an anoraxigenic agent in the treatment of obasity. It may ba used in simple obesity and in obesity complicated by diabetas, moderata hypartension (see Pracautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disaasa, hyperthyroidism, severe hypertension, nervous instability, and agitatad prepsychotic states. Do not use with other CNS stimulants, inciuding MAO inhibitors.

Warning: Do not usa during tha first trimester of pregnancy unless potential benefits outwaigh possibie risks. Thare have been clinical reports of conganital malformation, but causal relationship has not been proved. Animal taratoganic studias hava been inconciusiva.

Precautions: Usa with caution in modarata hypertension and cardiac decompansation. Casas involving abusa of or dependenca on phenmetrazine hydrochloride have bean reported. In genaral, thesa cases wera charactarized by axcassive consumption of the drug for its central stimulant effect, and hava resulted in a psychotic illness manifested by restlassness, mood or behavior changas, hallucinations or delusions. Do not exceed racommanded dosaga.

Advarsa Reactions: Dryness or unpleasant taste in tha mouth, urticaria, ovarstimulation, insomnia, urinary frequency or nocturia, dizziness, nausaa, or haadache.

Dosage: Ona 25 mg. tablat b.i.d. or t.i.d. Or ona 75 mg. Endurets tablet a day, takan by midmorning.

Availability: Pink, squara, scored tablats of 25 mg. for b.i.d. or t.i.d. administration, in bottias of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Undar license from Boehringar Ingalheim G.m.b.H.

For compiata detalls, plaasa see full prascribing information.

Gaigy Pharmaceuticals
Division of Gaigy Chemical Corporation
Ardsiay, New York 10502

She runs good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

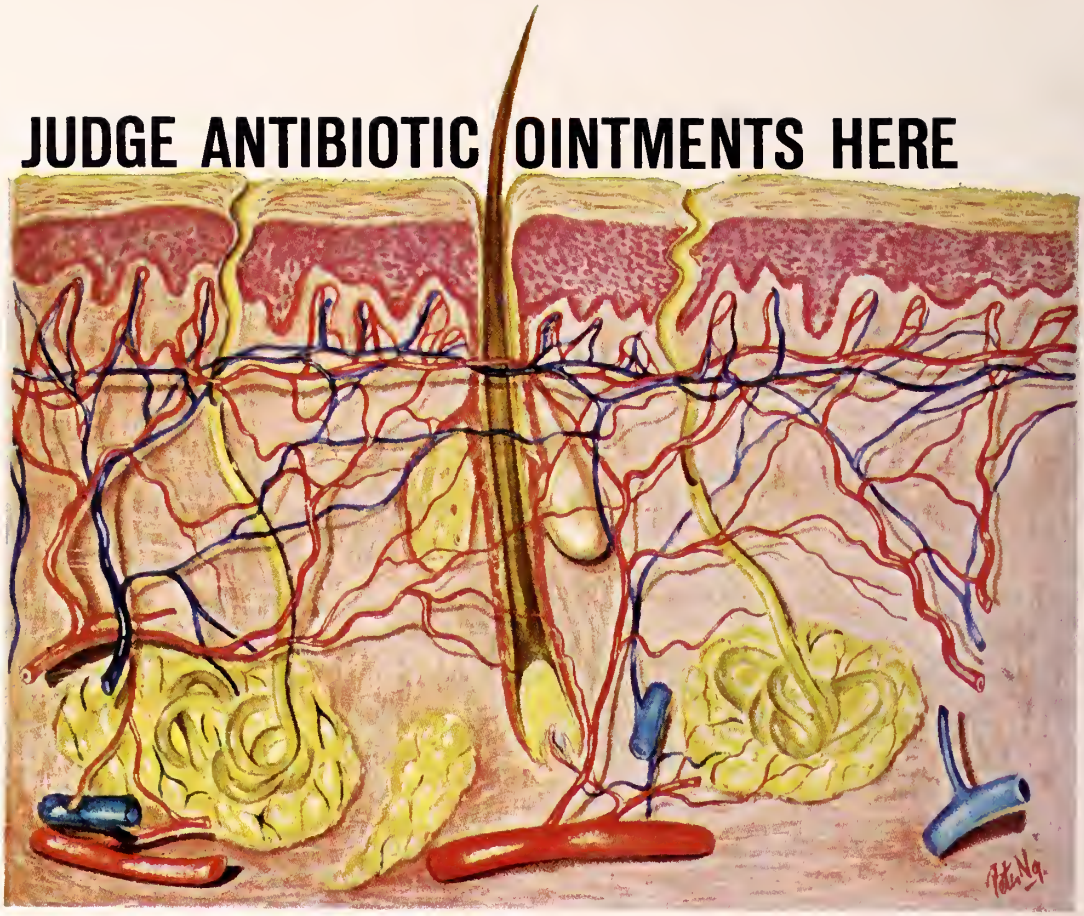
One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

Q. How many Blue Shield subscribers have coverage for out-of-hospital diagnostic services such as laboratory and x-ray and why isn't this type of coverage more widespread?

A. *At the present time, there are in excess of 50,000 certificates in force representing over 155,000 Blue Shield members having some type of coverage for out-of-hospital diagnostic laboratory and x-ray services. Blue Shield is very aware of the need for this type of coverage and our enrollment staff is constantly attempting to upgrade coverage and to include diagnostic outpatient services. Benefits for out-of-hospital x-ray and laboratory up to a maximum of $100 per contract year are automatically offered with Usual and Customary Blue Shield group proposals. However, the acceptance of these benefits is strictly voluntary with little assurance that they will always be taken.*

Q. What information is needed to file for out-of-hospital diagnostic services?

A. *A Blue Shield Service Report should be filed including the provisional diagnosis or symptomatic complaint. The definition for out-of-hospital diagnostic laboratory or x-ray service is: x-ray or laboratory exams required in the diagnosis of any condition of disease or injury. One of the exclusions under this type of coverage is diagnostic laboratory or x-ray services in connection with routine physical examinations or checkups. You can readily see why it is necessary that Blue Shield have the provisional diagnosis or symptomatic complaint. Also needed are the date and description of the service rendered and a breakdown of the charges for each service.*

Q. What Blue Shield Endorsement covers out-of-hospital diagnostic x-ray or laboratory services?

A. *At the present time, there are 24 endorsements providing benefits for out-of-hospital diagnostic x-ray and laboratory examinations. Benefits range from $50 per contract year to $200 per calendar year. The most prevalent such endorsement is Endorsement VA, which allows a maximum payment of $50 per contract year for each member covered under that certificate number. Your Blue Shield Physicians' Manual lists each such endorsement with a full explanation of benefits and limitations.*

Q. How do I determine what Blue Shield's allowance will be for an out-of-hospital diagnostic x-ray or laboratory procedure?

A. *The Schedules of Indemnities for Endorsements V and VA are included in the Blue Shield Physicians' Manual. The indemnity allowance for a specific diagnostic x-ray or laboratory procedure may be determined by referring to this manual. The remaining indemnity endorsements are special endorsements established according to the specific requests of group purchasers. Allowances under these special endorsements may be determined through correspondence with Blue Shield. Under Usual and Customary Blue Shield, allowances for out-of-hospital diagnostic laboratory and x-ray services are made according to the Usual, Customary and Reasonable charges for a specific procedure within a given medical-economic area.*

PUBLIC HEALTH PAGE

The Planned Family: A Public Health Goal†

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

WE seek to assure:

That every child be well born,
That he is wanted,
That he has the opportunity to realize his full potential,
That he has the opportunity to acquire a good education,
That he has the opportunity to receive all the medical services he needs,
And that he becomes a responsible citizen.

Recent interest and concern at federal, state and local levels regarding the expanding world population have resulted in new and significant developments in the area of family planning.

Family planning services became an official Health Department activity in April, 1966. The Family Planning Program is under the direction and supervision of the Division of Maternal and Child Health of the Kentucky State Health Department. Contraceptive supplies and consultant services are purchased with federal funds from the Children's Bureau.

The Health Department family planning services are available to any woman who is unable, for any reason, to obtain such service through a private physician, hospital or clinic. Physicians in private practice and community health and welfare agencies may refer patients for family planning services.

Family Planning services are provided through local health departments or agencies designated by local health departments. The case finding, health education, clinic services and follow-up are provided by the local health department staff with consultation from local physicians in private practice, the local health officer and the Division of Maternal and Child Health.

Before family planning services can be initiated by a local health department, with supplies obtained from the Division of Maternal and Child Health, the program must be approved or endorsed by the local county board of health.

At the present time family planning services are provided by 92 county health departments in Kentucky. About 10,000 women have received contraceptives through this program. This number does not include consultations and instructions in the rhythm method.

Each participating health department naturally has its own problems, its own rules and arrangements for family planning services. However, in order to insure high quality of care, all health departments are required to follow the standards and guidelines set up by the Division of Maternal and Child Health.

Clinic services at the time of admission to the Family Planning Program must include the following procedures: 1) complete medical and social history, 2) pelvic examination, 3)

†*This article was prepared by Astra U. Kidd, M.D., M.P.H., director, Maternal, Infant and Preschool Program, Division of Maternal and Child Health, and Jo Anne Sexton, M.D., acting director, Division of Maternal and Child Health, Kentucky Department of Health, 275 East Main Street, Frankfort, Kentucky 40601*

breast examination, 4) height and weight, 5) blood pressure, 6) urine-albumin and glucose, 7) hemoglobin or hematocrit, 8) Pap. smear, 9) GC smear and 10) serology.

The indications and needs for the above procedures are frequently questioned by non-medically oriented agencies. The Division of Maternal and Child Health requires these procedures for the following reasons: 1) a large number of the health department family planning patients are medically indigent and this is their first exposure to medical screening procedures and 2) the Division of Maternal and Child Health considers family planning an integral component of maternity care. As a rule, women within child bearing age are potential maternity cases and should be prepared physically, nutritionally and mentally for their next pregnancy. A comprehensive Family Planning Program provides an opportunity to do this as much as possible.

According to the most recent statistical information available, Kentucky has a total population of 3,195,500. Of this number 626,300 are women within child bearing age. Family Planning Services should be available to all women who need or request this service.

The Kentucky State Health Department Family Planning Program has been very limited due to lack of money and manpower. Since federal money is now being channeled into special projects such as Model Cities Programs, there will be no increase in funds for expansion of family planning services in the near future. Aid to Family Planning Programs must come from local resources—businesses, county agencies, clubs and individuals. Family Planning is a community problem and a community responsibility.

Mark Your Calendar

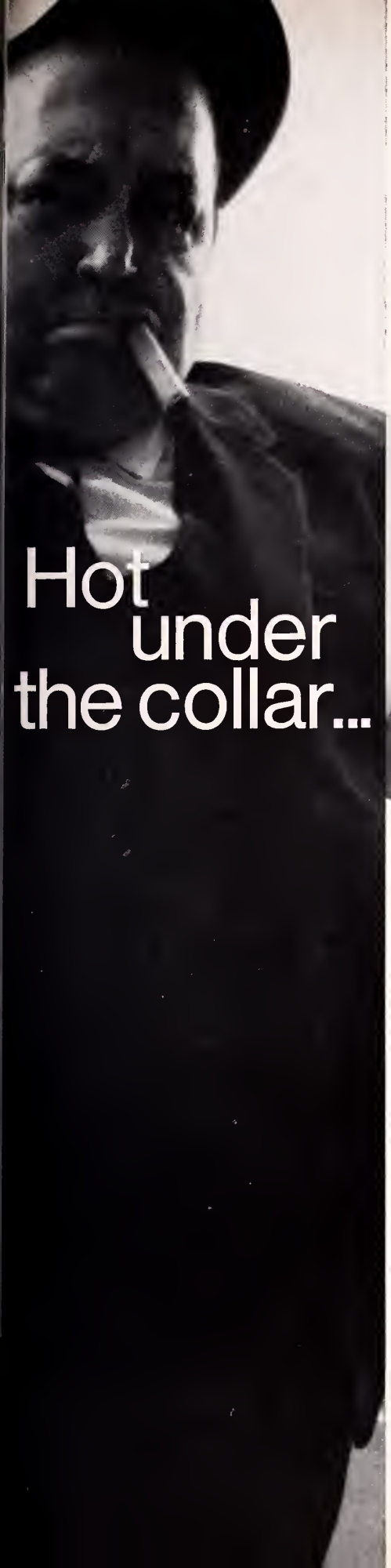
1969

KMA ANNUAL MEETING

September 23-25

Convention Center

Louisville



Hot under the collar...



high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such
patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

Medical Economics says:

GENERAL LEASING'S PLAN IS

"The Winning Way"

TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ Leasing better than buying
- ★ No capital investment
- ★ Dependable car at all times
- ★ Certain tax advantages
- ★ Call us for particulars

LEASE
Medical or Surgical
EQUIPMENT

- ★ A plan for young doctors
- ★ Medical and Surgical equipment
- ★ Complete office furnishings
- ★ Enlarging facilities
- ★ Call us for full details

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207

SUBTLE SEDATION

Solfoton

Sedation without peaks and valleys

REMOVES THE MENTAL BLUR
THAT CLOUDS VISION

CONSTRUCTIVE THERAPY—Solfoton in any form taken at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Each tablet or capsule contains:

PHENOBARBITAL (Warning: may be habit forming) ... 16 mg.
BENSULFOID® (See P.D.R.) 65 mg.

Precaution: same as 16 mg. phenobarbital

Literature and clinical supply available to physicians.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

SOLFOTON (yellow, uncoated tablets "P")
100s, 500s, 5000s

SOLFOTON CAPSULES (yellow and brown)
100s, 500s, 1000s

SOLFOTON S/C (sugar-coated, beige tablets)
100s, 500s, 4000s

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

Solfoton®

SUBTLE SEDATION

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

IN KENTUCKY

MAY

14-15 Kentucky Chapter, American Academy of Pediatrics Annual Spring Meeting, Holiday Inn, Somerset

15 Eleventh KMA Trustee District Meeting, Madison Country Club, Richmond

16-17 Kentucky Chapter, American College of Surgeons and Kentucky Surgical Society Joint Meeting, Holiday Inn, Somerset

16-18 Kentucky State Association of Medical Assistants Seventh Annual Convention, Holiday Inn, Elizabethtown

22 Third KMA Trustee District Meeting, Princeton Country Club, Princeton

28 Thirteenth KMA Trustee District Meeting, Ashland

28-29 Continuing Education Course "Perinatal Symposium," University of Kentucky College of Medicine, Lexington

29 Fourteenth KMA Trustee District Meeting, Pikeville

JUNE

4 Ninth KMA Trustee District Meeting, Paris

10 Second KMA Trustee District Meeting, Owensboro

11 Twelfth KMA Trustee District Meeting, Somerset

23 St. Joseph Infirmary Cancer Symposium, Lourdes Hall, Louisville

JULY

16-17 KAGP Seminar, Jenny Wiley State Park, Prestonsburg

AUGUST

24 KAGP Bluegrass Seminar, Lexington

IN SURROUNDING STATES

MAY

14-16 National Society for the Prevention of Blindness, Inc., Annual Conference, Pfister Hotel, Milwaukee, Wisconsin

21-23 Mid-South Medical Association, Holiday-Inn Rivermont, Memphis, Tennessee

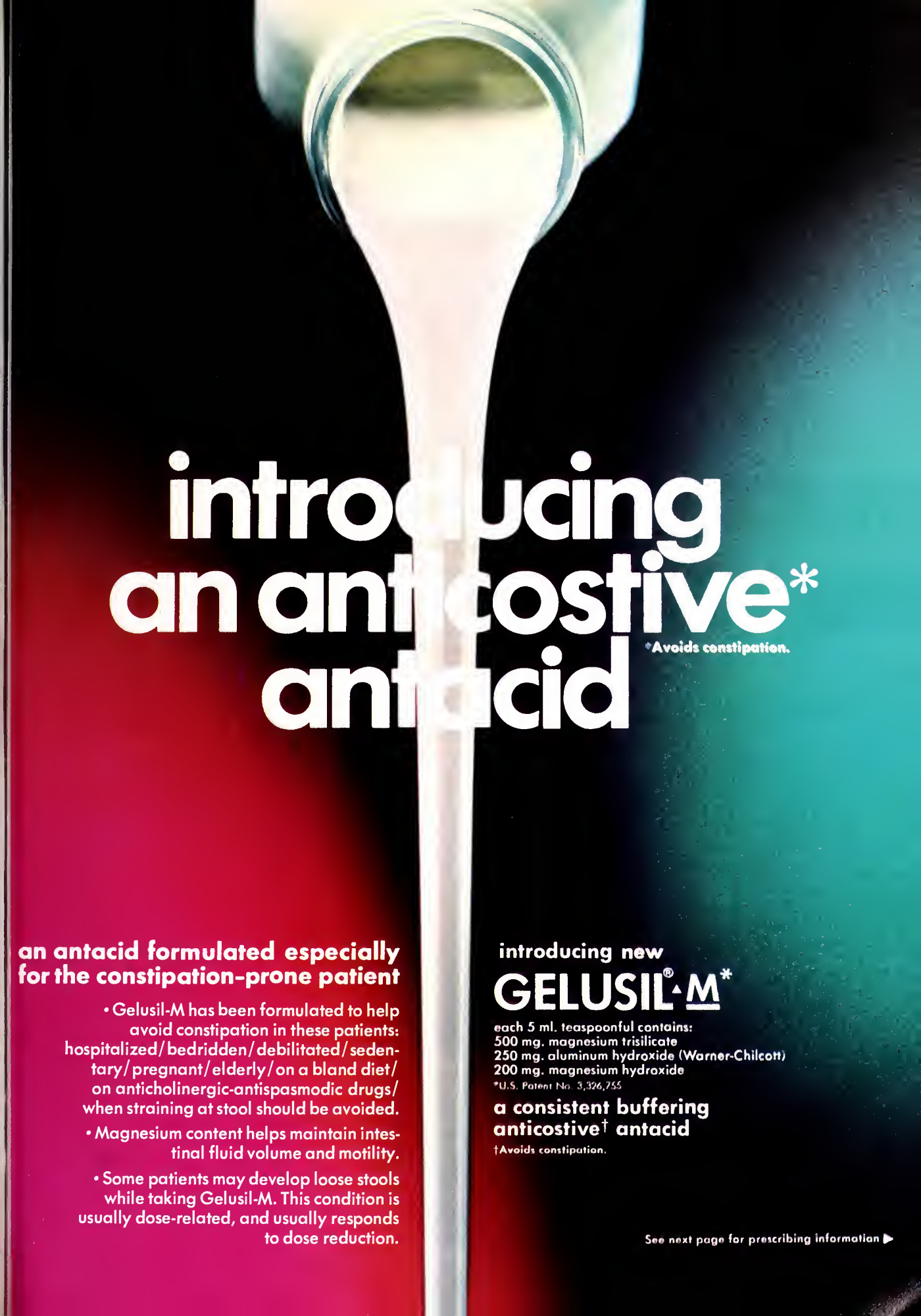
JULY

13-17 American Medical Association, 118th Annual Convention, New York, N.Y.

14-18 Simulation of Biological Systems Seminar, Los Angeles Analysis and Computation Center, Los Angeles, Calif.

AUGUST

10-15 American Congress of Rehabilitation Medicine Annual Session, Palmer House, Chicago, Ill.



introducing an anticostive* antacid

*Avoids constipation.

an antacid formulated especially for the constipation-prone patient

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patien



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

a universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquic

when constipation is not a problem

Pleasant mint flavor...ideal for hospi tal or home. Available in 12 fl. oz. an 6 fl. oz. bottles and a special hospitc pack. An antacid which contains adsor bent and demulcent agents in each ml. teaspoonful: 0.25 Gm. aluminun hydroxide (Warner-Chilcott), 0.5 Gm magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)– or more—between meals and at bed time, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-92-4C

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1969 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 23, 24, 25**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

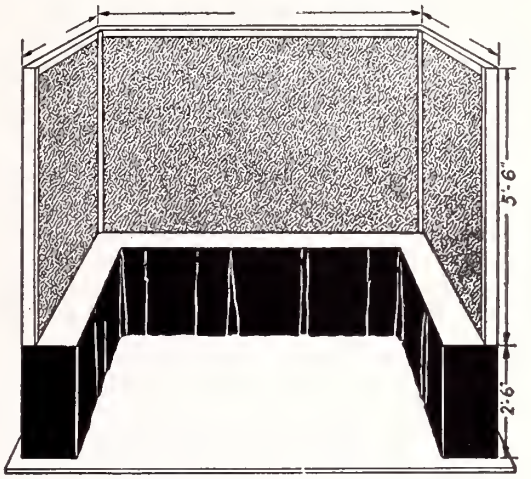
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1969

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)
 Institution (if desired):
 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)
 Charts and Posters.... Photographs.... Drawings.... X-rays
 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:
 Amount of total wall space needed?
 Back wall Side walls (All side walls are 4')
 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided to you in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 MAY, 1969 No. 5

Regional Enteritis and Chronic Ulcerative Colitis†

COLEMAN C. JOHNSTON, M.D., F.A.C.S.*

Lexington, Kentucky

A discussion of the similarities and differences of regional enteritis and ulcerative colitis, their differential diagnoses and treatments, and a review of the incidence of these diseases in similar northern and southern hospitals is presented.

THE clinical panorama of inflammatory disease of the large and small bowel presents a vast and confusing picture to the physician whose lot it is to fall heir to the treatment of these unfortunate people.

Chronic nonspecific ulcerative colitis and regional enteritis head the list; however, amoebic and bacillary dysentery, the irritative enteritides, tuberculosis, actinomycosis, and a multitude of tropical and deficiency diseases must all be included. The symptomatology of lymphopathia venerea, diverticulitis, the lymphomas and carcinoma may further confuse the picture.

Recently, a good deal of attention has been devoted to regional enteritis or Crohn's disease and chronic ulcerative colitis—their similarity, their difference, their differential diagnosis, treatment, and whether or not they are related diseases. In Prague at a recent meeting of the International Congress of Gastroenterology, a symposium on this subject stimulated controversy second only in intensity to that of the Russian invasion of Czechoslovakia. Crohn[1] himself was there to defend with vigor the two disease concepts.

Though these diseases are not frequently seen in a general surgical practice in our area, we are called upon sufficiently often to treat these patients to warrant a thorough understanding of the problems that accrue when confronted with the responsibility of surgical consultation.

In a five year review (January, 1963 to December, 1967) of 68,268 admissions to St. Joseph Hospital in Lexington, Kentucky, only 15 cases of regional enteritis or .2/1,000 and 47 cases of chronic ulcerative colitis or .7/1,000 were found. This surprisingly low figure suggested a geographic or environmental influence.

To explore this possibility, 10 comparable hospitals were selected. Five south central states' hospitals from Kentucky, Tennessee, Alabama, and North Carolina, and five eastern states' hospitals from Massachusetts, New York, and Pennsylvania were chosen and their admissions for an 18-month period were reviewed. The southern hospitals recorded an incidence of regional enteritis of .4/1,000 and chronic ulcerative colitis 1.1/1,000 compared with the eastern hospitals' regional enteritis .7/1,000 and chronic ulcerative colitis 1.0/1,000. In the colored patients of the southern

†*Presented at the meeting of the Kentucky Chapter, American College of Surgeons, Louisville, Ky., September 26, 1968*

**Associate professor of surgery, University of Kentucky College of Medicine*

hospitals, regional enteritis was three times more common than in the north. Chronic ulcerative colitis was three times more common in northern colored patients. We, therefore, note very little difference in the incidence of the disease in the south central and eastern states.

The St. Joseph's 15 patients with regional enteritis had 21 admissions and 13 operations, their ages ranging from 17 to 64, an average of 36 years. There were eight female and seven male. Those with chronic ulcerative colitis numbered 47 and had 80 admissions and 11 operations. One-third were male, ranging in age from 11 to 75, an average of 42 years. This presents an interesting contrast between the prolonged morbidity of the perforce conservative treatment of chronic ulcerative colitis and the more perfunctory treatment of regional enteritis.

Although the etiology of both Crohn's disease and chronic ulcerative colitis is still a matter of conjecture, there is considerable evidence to support the concept of a strong genetic factor. Regional enteritis was found to occur in .7/1,000 of the Jewish population in Baltimore and 10 percent of these patients had close relatives suffering from granulomatous disease of the bowel. The common association of these diseases with Polyarthritis, eczema, allergic manifestations and ankylosing spondylitis would suggest a pathophysiological relationship of interest. The collagen diseases also share some of their characteristics with chronic ulcerative colitis and regional enteritis.

Patterson [2] *et al* note an erythrocyte glucose-6-phosphate dehydrogenase deficiency, due to a group of related mutations of enzymic structure, in patients with granulomatous disease but not chronic ulcerative colitis.

Perlmann[3] in Stockholm describes two mechanisms of autoimmune antibody formation against the colon which create an immunological imbalance. The infectious disease concept in chronic ulcerative colitis is again being given serious thought because of the clinical responses to the sulphones, sulfaparadine and paraminobenzoic acid compounds. In short, current study has far from settled the question of the etiology of either of these diseases.

Although the clinical picture of early regional enteritis and chronic ulcerative colitis is often indistinguishable, the pathological alterations of the bowel wall are as clearcut and distinctly different as are cystic mastitis and carcinoma of the breast.



FIGURE 1: Initially, Crohn's disease or regional enteritis was thought to be limited to the terminal ileum. Note 10 cm. of normal ileum included with the resected specimen of regional enteritis involving the terminal ileum down to but not beyond the ileocecal valve.

Initially Crohn[4] observed that, in this disease, the colon and rectum were never involved. Morson, Lockhart-Mummery[5] and others have noted that Crohn's disease may involve all or any part of the colon and is often found in the rectum with or without small bowel involvement. By the same token, chronic ulcerative colitis may invade the terminal ileum. This is described as back-wash ileitis. The co-existence of small bowel regional enteritis and large bowel chronic ulcerative colitis as well as the reverse have been reported. Regional enteritis is found to involve the small intestine 85 percent of the time and the colon 15 percent while chronic ulcerative colitis involves the colon 66 percent of the time

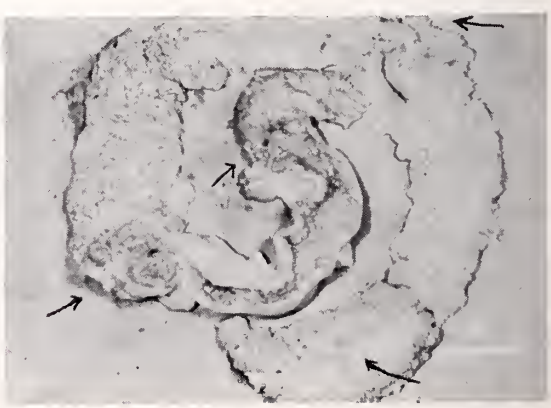


FIGURE 2: This specimen of regional enteritis illustrates ileocecal involvement with skip areas of the disease at the splenic flexure and sigmoid.

and the ileum 34 percent. Regional enteritis has been found in the jejunum, duodenum, stomach, and even in the esophagus. So, there still remains a peculiar, though unexplained, interrelationship between these diseases.

In regional enteritis, grossly there is usually a discrete surface area of grey or reddish-purple discoloration appearing to involve a rubber hose-like segment of bowel with a thickened corrugated feel of the mesentery. Typically, the small bowel is involved down to the cecum. The diameter of the lumen is diminished by the thickened wall of the fat covered bowel. All coats are affected. X-ray will usually reveal the diseased and deformed ileum. The bowel is usually involved in continuity though in 10 percent "skip areas" are found. In about 30 percent, abscesses or fistulae may compromise still other loops of large or small bowel, bladder, vagina, rectum, or even the abdominal wall. About 5 percent become obstructed.

Warren and Sommers[6] point out that, microscopically, the disease process is a progressive granulomatous lymphangitis gradually sclerosing the lacteals and lymphatics in the mucosa, submucosa, muscularis, and serosa. This eventually produces what amounts to an elephantiasis of the entire bowel wall, mesentery, and lymph nodes.

Fibrous tissue and giant cell proliferation with granuloma formation and progressive cicatrization produces bowel wall thickening and mucosal ulcerations which results from circulatory constriction and occlusion. At first, the mucosal ulcerations are longitudinal, overlying the mesenteric border. Submucosal abscesses develop and burrow to undermine the mucosa, then transverse ulcerations appear giving a cobblestone effect. Larger abscesses penetrate the bowel to produce perforation or fistula. Since all coats of the bowel wall are involved in the granulomatous disease of regional enteritis, it is recognized grossly by the surgeons and microscopically the pathologists with relative ease.

Chronic ulcerative colitis, on the other hand, is an exudative disease primarily involving the mucosa and submucosa of the bowel. Grossly at operation, the surface of the colon has an inflamed reddish discoloration. The exaggerated spasticity of the colonic musculature eliminates the haustrations and thickens the wall,



FIGURE 3: This specimen illustrates the typical ulceration and cicatrization of chronic nonspecific ulcerative colitis.

causes the lead pipe x-ray appearance, and, with the ultimate scarring and contracture, often shortens the length of the colon by one-third or more.

The specific pathology in chronic ulcerative colitis is confined mostly to the mucosa and the submucosa. Large segments of or all of the colon are involved in continuity, at first in a superficial diffuse inflammation of the mucosa. With progress, small cystic abscesses develop which rupture into the submucosa to burrow and undermine the mucosa.

Healing and scarring result in constriction and eventual occlusion of the mucosal blood supply with resultant slough and extensive ulceration. Superficial but extensive ulceration may completely divide large areas or islands of mucosa that remain between the cleaned out ulcer bases. Undermined strips of mucosa may be attached at both ends or may form long worm-like projections. The pesudopolyp develops from cicatrization about the base of the mucosal islands or areas of regenerated mucosa. The muscularis and serosa are rarely involved except in advanced states of degeneration, and the granulomatous changes are absent.

In the fulminating disease, vascular lesions resembling periateritis nodosa or thromboangitis obliterans, spoken of as vasculitis colitis, seem to produce large areas of ischemic necrosis that may result in extensive bowel wall slough with massive perforation accounting for about 40 percent of the fatalities. The most poignant description of the gross pathology in this unfortunate state was made by a surgeon who commented, "like wet toilet paper, the whole anterior wall of the cecum

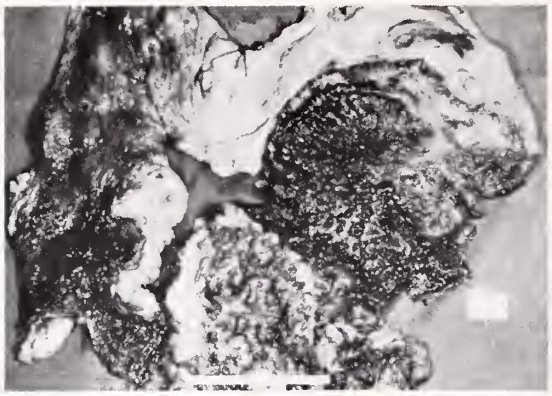


FIGURE 4: This specimen reveals areas of denuded and necrotic mucosa in the acute toxic dilitation of the colon in nonspecific chronic ulcerative colitis.

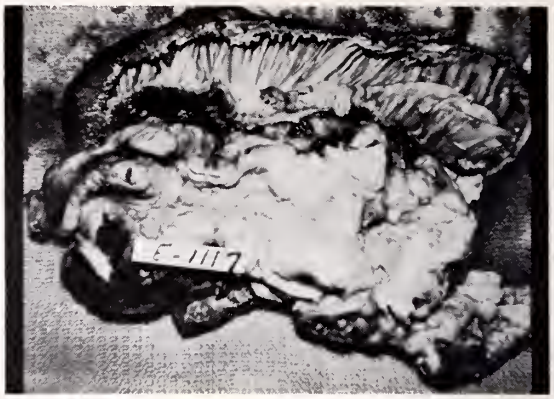


FIGURE 5: This specimen illustrates the scarred and thickened granulomatous involvement of the obstructed terminal ileum with proximal dilitation of the small intestine in regional enteritis.

came off in my hand". Though that was obviously not the time the internist should first admit defeat and seek surgical consultation, it still occurs occasionally.

The autopsy findings of multiple organ involvement of patients dying of nonspecific ulcerative colitis strongly suggests the possibility of a systemic disease with the focal point in the colon.

The clinical picture of nonspecific ulcerative colitis may range all the way from the mild low grade diarrhea of the chronic disease to the fulminating lethal toxic colitis gravis which may occur with the initial attack or superimpose itself upon any one of many late recurrences. Death may supervene within three to five days.

Early, the symptomatology of chronic ulcerative colitis may be indistinguishable from that of regional enteritis of either the small or large bowel but, with time, the stools become more frequent and irritating, containing blood and pus. There are more cramping, colicky episodes often associated with severe pain. Perianal and rectal pain can be intense with severe tenesmus when fissures or fistulae are present. As fever, malaise, general debility, and depression become more marked, patients seem to deteriorate more readily than in Crohn's disease. Unexplained remissions may appear to last from weeks to years only to recur with renewed vigor. There is a strong emotional overlay in chronic ulcerative colitis. This element is far less evident in regional enteritis as is the intensity, severity, and rapidity of the development and progress of the clinical symptomatology.

The clinical picture of Crohn's usually is that of a young adult complaining of mild to moderate lower abdominal discomfort, two to four or five loose or semi-solid stools a day, usually associated with mucous and occasionally blood streaked. These patients often present several months to two years after the onset of their disease. Weight loss, a moderate to severe degree of anemia may be present, and a history of episodes of fever of varying intensity and duration is usually elicited. This disease is persistent, usually mild at first, though continuous and progressive. Remissions may occur. With time, progress and the ultimate pathological changes that occur, extensive areas of ulceration, bowel wall thickening and cicatrization develop and progressive obstructive symptoms occur. In place of the foul fatty diarrhea, constipation may develop. Cramping colicky pain appears with slowly increasing intensity. Loss of appetite, mild to moderate nausea, and finally vomiting occur as the obstruction becomes more intense or complete. In patients who have involvement of the colon with or without the small bowel disease, anorectal pathology is often found in the form of fissures, abscesses, or one or more indolent fistulae.

At sigmoidoscopy, the mucosa may resemble the diffuse granular appearance of chronic ulcerative colitis. It may be normal or diffusely edematous with scattered areas of small ulceration. Often, if there is anorectal disease with fistula or ulceration within reach, biopsy will reveal the typical pathology of Crohn's disease or chronic ulcerative colitis and, thereby, establish the diagnosis.

In regional enteritis, indolence and chronicity are the key factors in this slowly progressive disease. Acute or critical episodes usually occur late in association with the complications of the disease.

Schwarz[7] of Vienna observed in 1912 that, on x-ray examination, chronic ulcerative colitis manifests itself as a small, smooth bowel with absent haustrations. Since then, diffuse superficial and deep ulcerations are also noted and segmental involvement is occasionally seen. Ultimately, marked shortening of the colon is evident.

Marshak[8] observes that Crohn's disease of the colon is immediately suspect if ileal alterations are noted on x-ray. Characteristic of granulomatous disease of the colon are skip areas, longitudinal ulceration, transverse fissures, eccentric involvement, and the cobblestone effect from pseudopolypoid changes. Diminished lumen with thickened wall produces the string sign and a rigid tube-like appearance of the bowel. Dockerty[9] and others feel that, as these diseases have many characteristics in common, the differential diagnosis at x-ray is often difficult.

The possible relationship between chronic ulcerative colitis and carcinoma of the large bowel was first suggested by Crohn[10] in 1925 and reaffirmed two years later by Yeomans.[11] By 1928, Bargen[12] reviewed 20 cases at the Mayo Clinic and there is an ever increasing accumulation of data to support this thesis. By the same token, it has become increasingly evident that, in Crohn's disease, carcinoma is almost never found.

The incidence of cancer associated with chronic ulcerative colitis has been recorded as ranging from one to 11 percent. Iain MacDougall[13] calculated the incidence of carcinoma of the colon with complete colitis as 30 times, and carcinoma in the rectum as 65 times that of the normal population. All agree the incidence of carcinoma is far higher in patients whose ulcerative colitis developed in childhood. Brown[14] noted that carcinoma develops on the average of 10 years earlier in patients with chronic ulcerative colitis than in the normal population. Kirsner[15] showed it is more widely distributed throughout the bowel. In nearly half of Brown's series, two or more cancers were present and almost two-thirds of

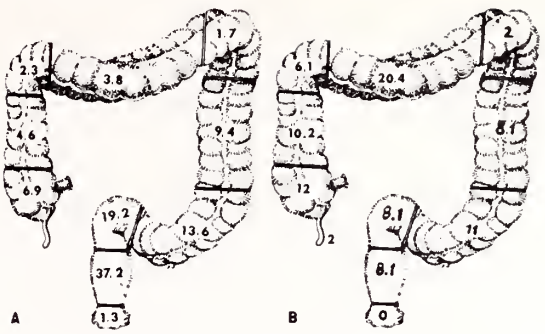


FIGURE 6: This diagram, taken from an article by Goldgraber and Kirsner, illustrates the difference in distribution of cancer of the colon in A, the uninvolved bowel, and B, the colon with non-specific chronic ulcerative colitis.

these patients died of carcinoma. Malignant disease associated with chronic ulcerative colitis, as pointed out by Lynn[16] and others, is of a higher grade, grows faster, metastasizes earlier, and is a more lethal disease than the usual carcinoma of the large bowel. It develops on the average of about 17 years after the onset of ulcerative colitis but has been recorded from one to 30 years thereafter. Cornes[17] reported an incidence of 22.4 percent after 15 years. Carcinoma has developed after a 10 to 16 year remission. Brooke[18] reported only an 18.6 percent five year postoperative survival in cancer associated with chronic ulcerative colitis. X-ray studies rarely reveal other than far advanced neoplastic disease and, as the history is entirely unreliable, most of these carcinomas are not found until they are incurable. These findings support the pessimistic view of MacDougall[13] who observed that 40 percent of patients with total ulcerative colitis, if not resected, will die of cancer.

There is much controversy as to the origin of carcinoma in chronic ulcerative colitis. Yeomans[11] felt that the pseudoadenomatous polyp was a precancerous lesion. Gillnäs[19] and others agree and postulate a direct relationship between the effect of prolonged inflammation upon the polyp and malignant degeneration.

Others, including Warren and Sommers,[20] believe carcinoma arises on a pre-existing adenomatous polyp or from the regeneration of epithelial hyperplasia.

The surgical treatment of these two diseases is quite different. The diagnosis of Crohn's disease is usually an indication for operation. Occasionally, the signs and symptoms are min-

imal and may subside. Medical management rarely contributes much to the ultimate outcome. Operation is indicated in progressive disease, obstruction, perforation, abscess, or fistula, hemorrhage, and acute dilitation of the colon.

Recently (and that is 35 years and 1,000 patients later), Crohn[21] observed that 77 percent of his patients required operation and between 30 to 50 percent developed a postoperative recurrence from three months to 25 years later. Colcock[22] reports a 35 percent recurrence rate and a need for reoperation in 25 percent. Of this group 25 percent will require a third operation.

Intractable disease demands exploration with a generous resection well above the grossly involved bowel. Obstruction requires adequate preoperative preparation with resection, remembering skip area involvement may occur distal to the obstruction. Abscess drainage or, if possible, removal with surrounding involved bowel are practical procedures. Fistulas, internal or external, single or multiple, must be excised with a generous removal of the offending segment of bowel. Bleeding, minimal prolonged or acute massive, is best controlled by a wide resection of the involved segment. The acute toxic dilitation of the colon, though rare in regional enteritis, is similar to that seen in chronic ulcerative colitis and is treated in a like manner.

Often, the acute process presents the clinical picture of appendicitis with peritonitis. Appendectomy is to be scrupulously avoided if only diffuse inflammation is found involving the terminal ileum, cecum, and appendix because of the high incidence of fistula following appendectomy in patients with regional enteritis. Simple closure is the proper approach for, as Crohn[23] observed, 50 percent of these acute episodes will subside. Subsequent operation may be necessary. If the cecum and terminal ileum are not involved in a proximal process that is not advisable to resect at the time of exploration, an appendectomy is then justified to avoid again the almost inevitable problem of differentiating between acute appendicitis and a recurrent episode of regional enteritis.

In the young, radical resection, when possible, is preferable. In the elderly, a bypass procedure similar to that used in President Eisenhower is safer and often quite satisfactory.

The treatment of early chronic ulcerative colitis is primarily medical and it is becoming increasingly more effective. Surgery is reserved for the treatment of medical failures, complications, and the eradication of irreversible pathological changes. It has been a long and uphill struggle from appendicostomy in the early 1900's for colonic irrigation to the single stage ileostomy and coloprotectomy of today. The struggle has been against an inordinately high mortality and morbidity because of the faltering uncertainty of the surgeon and the inadequacy of the ever increasing medical armentarium from the sulfa drugs to the steroids in the hands of the over enthusiastic internist who is reluctant to seek surgical aid. For this reason, in the late 1920's, the mortality for ileostomy alone was 33 percent. In the fulminating acute toxic dilitation of the colon, the nonoperative mortality was nearly 100 percent.

Almost every surgical alteration or modification one can think of has been tried to avoid ileostomy and save the anal sphincter. Few have been successful. Sigmoid or transverse colostomy for distal disease usually ends up with proximal involvement. Griffen,[24] *et al* presented an interesting 20 year experience with 50 patients treated with colectomy and ileorectal anastomosis for chronic ulcerative colitis. Fifty percent received good results. Two died of carcinoma arising in the rectal stump. Goldgraber[15] reported three similar cases. Aylett,[25] Fallis,[26] and others champion this procedure but Goligher[27] and many condemn it with equal vigor. In right-sided colitis and the normal rectosigmoid, this operation may be acceptable but more and more American surgeons feel that ileostomy and coloproctectomy is really the procedure of choice. Most of the sphincter-saving devices simply create an awkwardly placed ileostomy whose tidy housekeeping is utterly impossible.

Falconer[28] reported toxic dilitation of the colon 55 times in 400 patients with chronic ulcerative colitis. Perforation occurred in 16, severe hemorrhage in six. Falconer noted that, in toxic dilitation developing under medical management, early surgical intervention gives the highest percentage of survivals. He advo-

cates total proctocolectomy if the patient can tolerate so extensive a procedure. If not, total colectomy with subsequent removal of the rectum is advisable.

Turnbull, at the 1968 American Proctological Society meeting, commented on the "less than complete colectomy in acute toxic megacolon". He described the "blowhole procedure", a loop ileostomy, a right transverse and a sigmoid "blowhole" colotomy. The distended colon and sigmoid protrude through small incisions in the abdominal wall, are sutured to the skin, then opened and evacuated. This eliminates the danger of fracture on removal of the friable colon with massive contamination. A definitive resection is carried out after adequate rehabilitation.

At this point, it must be observed that, with prolonged or excessive use of steroids in the treatment of chronic ulcerative colitis, there is a very high incidence of postoperative complication. Large doses of Vitamin A are used to overcome the Cortisone effect.

Finally, it is probably safe to say that most surgeons feel that the only completely rehabilitated patient with diffuse chronic ulcerative colitis is one who has a properly made and functioning ileostomy and no colon, rectum, or anus with which to be concerned.

Summary

In conclusion then, it has been pointed out that the incidence of chronic ulcerative colitis and regional enteritis in the south, central, and eastern state population is quite similar and that chronic ulcerative colitis is about three times as common as regional enteritis. This small series is clinically insignificant with regard to treatment but it does point out the high incidence of readmissions and low incidence of surgery in chronic ulcerative colitis as compared with the reverse in regional enteritis.

The clinical etiologic and pathologic characteristics of chronic ulcerative colitis and regional enteritis have been reviewed and their similarities and differences discussed. It may be concluded that, although these diseases have many similarities, they are two distinctly different and unrelated entities.

A cursory survey of the vast literature on the surgical management of regional enteritis and chronic ulcerative colitis has been discussed and the operative procedures in current favor reviewed with the thought that these comments might be of interest to those of us confronted with these problems.

References

1. Crohn, B. B.: Relation of Crohn's Disease, Ulcerative Colitis Debated, *Hospital Tribune*: 8, (August 12) 1968.
2. Patterson, James F.: Regional Enteritis and Granulomatous Colitis Associated with Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency, *The New England Journal of Medicine*: 1124, (November 23) 1967.
3. Perlmann, Peter: Sources of Colon Antibody in Colitis Found, *Medical Tribune*: 14, (August 8) 1968.
4. Crohn, B. B. et al: Regional Ileitis: A Pathologic and Clinical Entity, *JAMA*, 99: 1323-1329, (October 15) 1932.
5. Morson, B. C. and Lockhart-Mummery, H. E.: Crohn's Disease of the Colon, *Gastroenterologia*, 92: 168-173, 1959.
6. Warren, S. and Sommers, S. C.: Cicatrizing enteritis (regional enteritis) as a pathologic entity; analysis of 120 cases, *American Journal of Pathology*, 24: 475-501, (May) 1948.
7. Schwarz, G.: Klinische Roentgendiagnostik des Dickdarms springer Berlin 1914: 153, quoted by F. B. McMahon and R. D. Carmen: Chronic Ulcerative Colitis and Its Roentgenologic Findings, *Collected Papers of Mayo Clinic*: 95-111, 1917.
8. Marshak, R. H. et al: Segmental colitis, *Radiology*, 73: 707-716, 1959.
9. Dockerty, Malcolm B.: *Am. J. Roentgenol*, 99: 24-34, (January) 1967.
10. Crohn, B. B. et al: The Sigmoidoscopic Picture of Ulcerative Colitis (Nonspecific), *Am. J. M. Sc.* 170:220, 1925.
11. Yeomans, F. C.: Carcinomatous degeneration of rectal adenomas. Report of 7 cases, *JAMA*, 89: 852, 1927.
12. Bargen, J. A.: Chronic ulcerative colitis complicated by malignant neoplasia, *Proc. Staff Meet. Mayo Clin.*, 3: 132, 1928.
13. MacDougall, Iain P.M.: The Cancer Risk in Ulcerative Colitis, *The Lancet*: 655-658, (September 26) 1964.
14. Brown, C. H. et al: Carcinoma of the Colon and Ulcerative Colitis, *Am. Journal of Digestive Disease New Series*, 10: 643-656, 1965.
15. Kirsner, Joseph B. and Goldgraber, Moshe B.: Carcinoma of the Colon in Ulcerative Colitis, *Cancer*, 17: 657-665, (May) 1964.
16. Lynn, D. H.: The relationship of chronic lesions to carcinoma of the colon chronic ulcerative colitis, Collective review, *Surg. Gynec. & Obst.*, 81: 269, 1915.
17. Cornes, J. S. et al: Primary Crohn's disease of the colon and rectum, *GUT*, 2: 189-201, 1961.
18. Brooke, B. N. et al: Cancer in Ulcerative Colitis, *Lancet*, 2: 694, 1959.
19. Gillnas, T. et al: In which phase of ulcerative colitis does colonic carcinoma occur?, *Am. J. Digest Dis.*, 3: 537, 1958.
20. Warren, S., and Sommers, S. C.: Pathology of regional ileitis and ulcerative colitis, *JAMA*, 154: 189-193, (January 16) 1954.
21. Crohn, B. B. et al: *Regional Ileitis;* 138-140, 1958.
22. Colcock, Bentley P.: Regional Enteritis, *Current Problems in Surgery*: 36, (June) 1965.
23. Crohn, B. B.: Acute Regional Ileitis, *N.Y. State Journal of Medicine*, 65: 641-644, (March 1) 1965.
24. Griffen, Ward O., Jr. et al: Ileoproctostomy in ulcerative colitis: long term follow-up, extending in early cases to more than 20 years, *Surgery*, 53: 705-709, (June) 1963.
25. Aylett, S. O.: Diffuse ulcerative colitis and its treatment by ileorectal anastomosis, *Am. Roy. Coll. Surg. Engl.*, 27: 260-284, 1960.
26. Fallis, L. S. et al: Modified technic for total colectomy in ulcerative colitis, *Arch. Surg.*, 67: 363, 1953.
27. Goligher, J. C.: Treatment of Chronic Ulcerative Colitis, *Current Problems in Surgery*: 6, (August) 1965.
28. Falconer, C. W. A.: Sources of Colon Antibody in Colitis Found, *Medical Tribune*: 14, (August 8) 1968.

Primary Inguinal Hernia Repair
A Report of One Hundred Cases

ROMEO S. BERARDI, M.D.*

McDowell, Kentucky

This report deals with 100 consecutive and unselected cases of inguinal hernia repair. The procedure employed by the author has been previously reported. No recurrences in a four-year follow-up program have been encountered.

INGUINAL hernia repair has drawn the attention of many prominent men in the field of general surgery and should draw the attention of all general surgeons, since it represents one of the more common operations performed and is by no means a closed chapter in surgery. Although recent advances[1,2,3,4,5] have done much to better our understanding of the anatomy and physiology of the groin, no one procedure can guarantee successful repair of all inguinal hernias.

As is known to all, deaths do occur as a result of some hernia complications. The complexity of the operation is entirely different in the uncomplicated case in which the anatomical repair is of primary concern as opposed to the complicated case in which the saving of a life may be at stake. With few exceptions, perhaps, all hernias should be repaired at the earliest possible time. The 100 cases reported in this series are consecutive and unselected in that no patient was denied a repair.

Probably no subject in surgery has as many operative procedures and approaches than the repair of inguinal hernia.[6,7,8,9,10] The procedure employed in the majority of these cases takes no exception. Although it is not original, its many incorporated features taken from already described procedures[6,9,10] make it unique.

*Chief of surgery, Daniel Boone Clinic, McDowell Regional Hospital

Method of Repair

The operative technique has been reported in the literature.[11,12] Briefly, a complete dissection of the hernial sac high into the internal ring and reduction of the size of the internal ring are two basic principles of the technique.[13] Although this may be the correct approach to the problem in infants and young children, further fortification is required in the adult to guard against recurrences. Therefore, additional support is provided to Hesselbach's triangle, since in many instances this has been weakened by a large indirect hernia and may become a potentially weaker area later in life, resulting in a direct hernia. This is accomplished by imbricating the transversalis fascia, suturing the internal oblique aponeurosis to the shelving edge of the inguinal ligament inferior and superior to the internal inguinal ring. The cut leaves of the external oblique aponeurosis are imbricated beneath the cord structures, thus completing the repair. The procedure provides a four layer repair in this area and is primarily a fascia and an aponeurotic layer-by-layer repair.

It is felt, even though the basic concepts are different in direct and indirect inguinal hernias, that the hernia repair should be of a type which takes care of the original hernia and also prevents the recurrence of a direct or indirect type, as the case may be. Experience has shown that at least 25 percent of the patients beyond 35 years of age have a concomitant direct hernia or will develop one in later life.[13]

Results

One hundred consecutive and unselected inguinal hernia repairs were performed from 1964-68. Ninety patients were males and 10 females, or 90 percent and 10 percent respec-

tively. The youngest was three months and the oldest 82 years, with a median age of 33 years. Thirty-four percent were over the age of 50.

The types of hernias encountered were as follows: indirect, 62; combined, 22; direct, four; associated femoral, seven; and recurrent, five. The recurrent hernias were either initially repaired elsewhere or were repaired at this institution before this study period.

Thirteen complications were noted: orchitis, five; hematoma of wound, one; pulmonary, three; and postoperative urinary retention, four. These complications occurred in nine patients, giving a morbidity of nine percent. No deaths occurred in this study.

Associated procedures performed were as follows: hydrocelectomy, six; appendectomy, four; orchiopexy, four; and epigastric herniorraphy, one.

The follow-up program consists of recalls at 3, 6, 12, 24, 36, and 48 months. One hundred percent have been followed to date and no recurrences have been noted.

General anesthesia was used with the exception of spinal in three and local in one. Early ambulation was encouraged in all patients. Those who were gainfully employed preoperatively returned to their former employment postoperatively.

Simultaneous repair of bilateral hernias was undertaken in 11 of the 100 patients. Ninety percent of the group were manual laborers.

Comments and Discussion

Since the primary objective of any hernia repair is to prevent recurrence, the ultimate effectiveness of any procedure should be judged in this light. In this study, no recurrences to date have been noted. Although our follow-up period only extends over four years with a median of 21 months, experience of a much larger series covering a 16 year period and in which the same operative technique was used, showed it to be below two percent.[13]

The many factors related to recurrences[14] are the duration of the hernia, type of hernia, condition of tissues, wound and general complications, tension on suture lines, surgical technique, and knowledge of the anatomy and physiology of the area. It is our feeling that the recurrent rate should never be any higher than three percent.

Postoperative testicular swelling is usually caused by rough handling and dissection of the cord structures and/or excessive tightening of the internal ring. The gauge that is used to determine the adequate tightening of the internal inguinal ring is the ease with which the blunt end of the ordinary thumb forceps enters. In this study all postoperative orchitis was either associated with a concomitantly performed hydrocelectomy or orchiopexy.

It has been our policy to accept for consideration all patients with an inguinal hernia for repair. We strongly feel that the nonoperative management of inguinal hernias in no way compares favorably with surgical repair. The zero mortality rate in this series of 100 consecutive and unselected patients testifies to the safety of the procedure.

We undertake simultaneous bilateral repair only on young, otherwise healthy adults, children or infants. Otherwise the hernias are repaired separately but usually during the same hospitalization with an interim of about five days between repairs. Recurrences are somewhat greater when simultaneous bilateral repairs are performed.[13]

Early ambulation is encouraged in the postoperative period. If the patient has a sedentary occupational position, he is allowed to return to work in three weeks, otherwise he is not allowed to return until six weeks postoperatively. We are, however, not convinced that a more rapid return to work would be associated with an increase in recurrences.

Summary

A review of 100 consecutive and unselected inguinal hernia repairs in a four year period is presented.

No recurrences to date have been encountered.

A morbidity of nine percent and a mortality of zero percent were noted.

Comments regarding some aspects of inguinal hernia repair have been offered.

References

1. Nyrus, L.M., Condon, R.E., and Harkin, H.N.: Clinical experiences with preperitoneal hernial repair for all types of hernia of the groin: With particular reference to the importance of transversalis fascia analogues. *Am. J. Surg.* 100: 234, 1960.

(Continued on page 378)

What's New in Prosthetic Heart Valves†

J. Kent Trinkle, M.D., F.A.C.S.* and Lester R. Bryant, M.D., F.A.C.S.**

Lexington, Kentucky

Improvements in artificial heart valve design and advances in operative technique have converted cardiac valve replacement from a desperate clinical trial to a routine operation to rehabilitate patients with valvular heart disease.

IN MANY areas of medical science a physician can examine several decades or even a century of progress in the evolution of a current mode of therapy. However, open heart surgery, and particularly the use of prosthetic heart valves, has evolved at a more rapid pace. In this field progress is measured in terms of a few years or months and even the brief time lag from the pen to the printer's ink may make this article partially obsolete. Some of the data presented is historical, but much has not been published and comes from manufacturer's bulletins, scientific meetings, and personal communications.

Artificial heart valves, of the general design now in use, were first implanted to replace a diseased mitral valve in 1960[1] and to replace an aortic valve in 1961.[2,3] Since that time valve replacement has become commonplace. Advances in surgical technique and extracorporeal circulation have lowered the initially high mortality rate. Improvements in valve design have reduced late complications and deaths, and yield better functional results. However, prosthetic valves are still used only in those patients in which the valve is so severely damaged, by scar and calcification, that functional reconstruction is impossible. This article is presented to appraise the practicing physician of the current status of prosthetic valve replacement in patients with valvular heart disease.

†*From the department of surgery, University of Kentucky Medical Center, Lexington*

**Assistant professor, division of cardiothoracic surgery*

***Associate professor, division of cardiothoracic surgery*

Valve Design

The following are some of the bioengineering problems encountered in creating suitable cardiac valve prostheses:

1. WEAR. At a heart rate of 80/minute, the prosthetic valve will open and close more than 42 million times per year. Durability is essential if the patient is to have a long life expectancy.

2. INERTNESS. The prosthetic material must be nontoxic and impervious to the action of various body substances such as electrolytes, lipids and enzymes.

3. INSERTION. The prosthesis must be quickly and firmly fixed in place. Since it must function immediately, rather than awaiting healing, the valve must be structured so that sutures alone can support it until tissue ingrowth fixes the prosthesis to the valve annulus.

4. GRADIENT. There must be minimal obstruction to blood flow across the valve so as not to create a pressure gradient with functional stenosis.

5. FUNCTION. The valve must open and close quickly and completely so that no insufficiency occurs.

6. POPPET. The poppet (ball or disc) must be of approximately equal density to blood so that, regardless of the patient's position, no lag occurs in the opening or closing of the valve.

7. CLOTTING. The valve material should not predispose to clot formation or peripheral emboli, and preferably not require anticoagulants.

Prosthetic heart valves now in use all operate on a ball-valve principle. (Figure 1) A ball or disc shaped poppet contained within a metal cage opens and closes during each cardiac

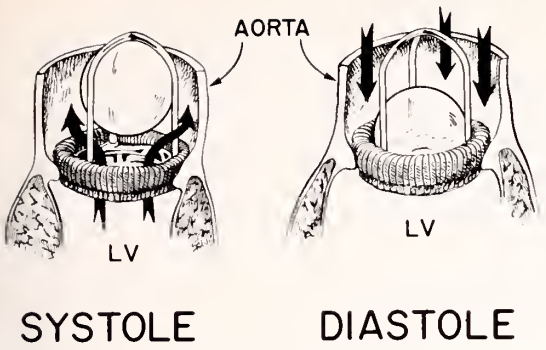


FIGURE 1 illustrates the ball-valve principle used in all prosthetic heart valves. During each cardiac cycle the ball alternately unseats allowing blood to flow through the valve orifice and then reseats to prevent regurgitation. The prosthesis is fixed to the valve annulus by multiple sutures passed through a cloth sewing ring which is fixed to the base of the prosthesis.

cycle. Although many different valves have been designed around this principle, only those which have been used at the University of Kentucky Medical Center will be described.

Aortic Valves

The only prosthetic valves used to replace diseased aortic valves at the University of Kentucky Medical Center have been the Starr-Edwards valves. This was the first ball-valve prosthesis used in patients, it is the most widely used aortic valve, and it has remained the standard by which other valves are judged. Figure 2 illustrates the three "generations" of Starr-Edwards aortic valves which have been used in patients—each one was modified to correct problems encountered with its predecessor.

Series 1000: (Figure 2A) This valve was used for approximately four years (1961-1965). The poppet is a silicone-rubber ball enclosed in a stellite cage. The sewing ring, through which sutures are anchored to the aortic annulus, is made of woven teflon. The early and late incidence of peripheral embolus was 20 percent.[4] Five year survival rate has been roughly 70 percent with this valve.[4,5] About 10 percent of the patients developed "ball-variance," which is swelling and damage to the poppet due to lipid infiltrate.[6] This led to a number of late, sudden deaths. Ball-variance can be detected by a decrease in amplitude of the opening "click" by auscultation or phonocardiography. A few patients developed late leaks around the base of the valve due to failure of tissue ingrowth into the teflon. This valve is no longer used.

Series 1200: The metal "feet" at the valve ring were eliminated since these were found to damage the surface of the poppet which in turn led to ball-variance.[6] No cases of ball-variance have been noted in this valve.[7] Knitted dacron was used for the sewing ring—this material allows tissue ingrowth to fix the valve firmly to the annulus and encapsulate the cloth with endothelium. This reduced the embolic rate to about nine percent, but anticoagulants are still required.[7] The poppet is impregnated with barium sulphate so that it is mildly radiopaque and can be visualized on an over-penetrated chest x-ray. Movement of the poppet can be evaluated by flouroscopy. This valve has been in clinical use since January, 1966.

Series 2300: This valve became available in January, 1968. It is entirely cloth covered with the hope that it would become totally encased in endothelium and anticoagulants could be discontinued after a few months. The poppet was changed to a hollow stellite ball since laboratory stress tests indicated longer wear than with the silicone-rubber poppet. Unfortunately the tissue ingrowth was too profuse and the orifice became narrowed. Cardiac catheterizations several months postoperative revealed an average pressure gradient of 39

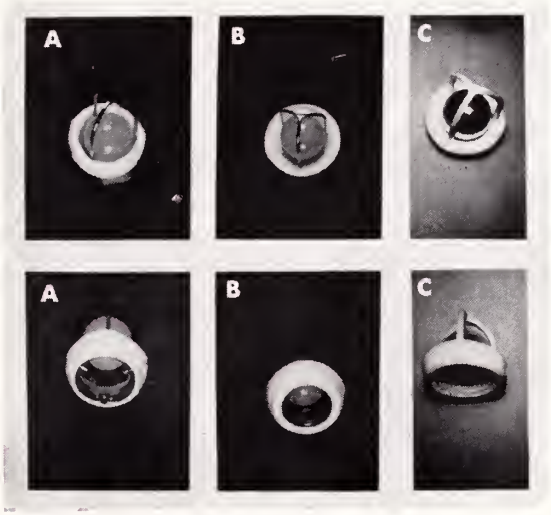


FIGURE 2 illustrates the three "generations" of Starr-Edwards aortic valve prosthesis.
A. Series 1000 valve - No longer in use.
B. Series 1200 valve - Currently being used.
C. Series 2300 valve - Currently being used only in patients with a large aortic annulus.

mm Hg across the *smaller* size valves. The average postoperative gradient across the series 1200 valves had been an acceptable 14 mm Hg. Subsequently the series 2300 valves have been modified to enlarge the orifice, line it with teflon and reduce the thickness of the knitted dacron—this should eliminate the problem of excessive tissue ingrowth with high gradients. Our present policy is to use the series 1200 valves in patients with aortic stenosis and a small aortic annulus who require a small valve (#8-10); and to use the cloth-covered series 2300 valves only in patients with aortic insufficiency and a large annulus requiring the larger sized valves (#11-14). The peripheral embolus rate from the cloth-covered valve has been reduced to about two percent even when anticoagulants have been discontinued after three to six months.

Mitral and Tricuspid Valves

When the aortic valve is replaced, the prosthesis protrudes into the aorta. With replacement of the mitral or tricuspid valve, the prosthesis protrudes into the cavity of the ventricle and, if the metal cage is too large, it can interfere with adequate emptying of the ventricle during systole. Thus the tendency has been to use a low profile or disc-type valve rather than a ball valve. (Figure 3) Since the disc valve occupies a smaller volume of the ventricle, it is hemodynamically superior. However, the long-term wear may not be as good, since a ball wears evenly on its entire surface while a disc wears only around its outer edge. The following valves have been used at this institution. (Figure 4 A-D)

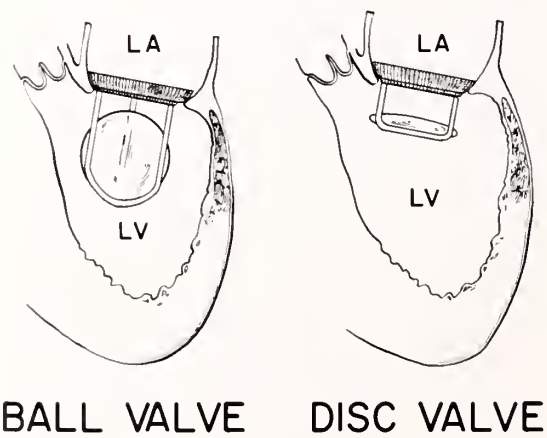


FIGURE 3 illustrates the difference between a ball-valve and a disc valve inserted in the mitral position. The low profile of a disc valve occupies a smaller volume of the left ventricle and results in better systolic function.

STARR-EDWARDS. Series 6000: This ball valve was used from September, 1960 to January, 1966. It is similar to the series 1000 aortic valve except that the orifice is much larger to fit the larger mitral annulus, and to allow blood to flow from the low pressure left atrium without a large gradient. The peripheral embolus rate with this valve was about 38 percent.[8] This valve is no longer used.

Series 6120: (Figure 4A) This was the second generation mitral ball valve and has been used since January, 1966. Like the series 1200 aortic valve, the poppet is impregnated with barium sulphate, there is less exposed metal, and the sewing ring is dacron. The embolus rate has been about three percent.[7,8]

Series 6500: (Figure 4D) This valve has been available since June, 1968. It is a disc valve which is cloth covered and has a hollow stellite poppet. As in the cloth covered aortic valves, the initial models were found to have excessive tissue ingrowth with narrowing of the orifice in the *smaller* sized valves. Cardiac catheterization several months postoperative revealed resting gradients of 5 to 12 mm Hg which is equivalent to mild mitral stenosis. The orifice size and cloth have been modified to correct this gradient but late data is not yet available. The embolus rate is zero percent to date.[7,9]

KAY-SHILEY (Figure 4B) This is a disc valve with a silicone-rubber poppet in a stellite cage.[10] It has the hemodynamic advantage of a low profile valve but still requires anticoagulants. The main problem with this valve is a narrow sewing ring which predisposes to leaks around the valve. This valve was used in all patients at this center with predominant mitral stenosis and a small left ventricular cavity from January, 1966 to February, 1968.

BEALL (Figure 4C) This valve has been used in almost all mitral and tricuspid valve replacements at this Center since February, 1968. It has a teflon disc poppet, teflon covered cage, and a loose dacron velour sewing ring. There is no exposed metal and the entire valve becomes encased in endothelium. Anticoagulants can be discontinued after three

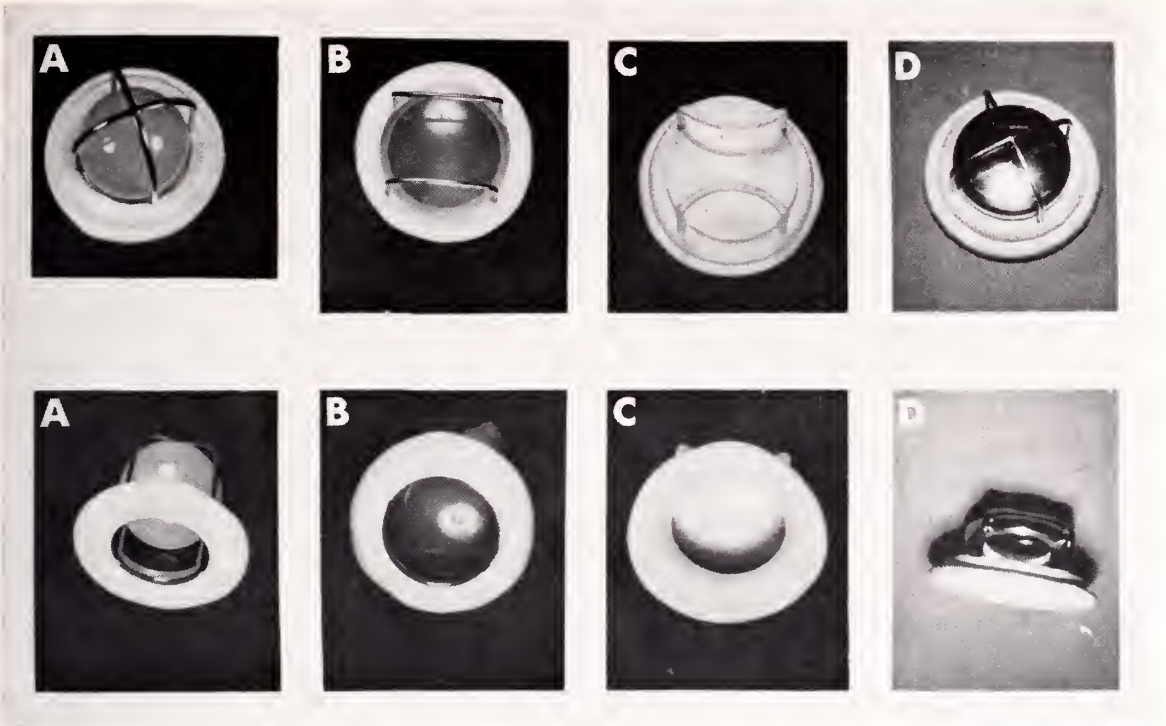


FIGURE 4 illustrates four of the five types of prosthetic valves which have been used for mitral and tricuspid replacement.

A. Starr-Edwards series 6120. The earlier model, series 6000 had more exposed metal at the base and the sewing ring was teflon rather than dacron.
B. Kay-Shiley Disc Valve.
C. Beall Disc Valve.
D. Starr-Edwards series 6500 Disc Valve.

months. Early and late embolization rate is one and one-half percent.[11]

Discussion

During the past nine years prosthetic valve replacement has progressed from a desperate clinical trial in a hopelessly ill patient, to a routine operation in patients with severe valvular heart disease. The improvements in artificial valve design have resulted from a massive expenditure of time and money by both surgeons and engineers. For each valve that reached the level of clinical trial, many were discarded after laboratory failures. Valves which are now being used in patients have an expected mechanical reliability of 30 to 40 years. This data has been obtained by stress testing the valves in the laboratory with a rapid-rate, simulated heart beat in an instrument called a "pulse-duplicator." However, we can only speculate whether or not the prosthetic materials will continue to function in the biologic environment of the heart as they functioned in the inert environment of the pulse-duplicator. While the basic principle of a ball-valve has been retained, for mitral and tricuspid replacement the low profile or disc valves have proved functionally superior—perhaps at the risk of a shorter mechanical life expectancy. Another major advance is the cloth covering which allows tissue encapsulation of the valve, decreasing the incidence of peripheral emboli from 20-30 percent with anticoagulants in earlier valves; to zero to two percent without anticoagulants in currently used valves. The major problem yet to be resolved is that of persistant gradients across the valve—particularly in tricuspid and mitral replacements where a relatively small gradient is functionally significant. The gradient is not progressive and is less than in the diseased valve being replaced. However, the gradient is still larger than desired for optimum cardiac function.

Concomitant with improvements in the structure of prosthetic heart valves have been improvements in operative technique and extracorporeal circulation. Initial experience with

prosthetic valve replacement in various centers carried an operative mortality rate of roughly 30 percent for a single valve, and 50 percent for multiple valve replacements. During the past year at this institution the mortality rate for aortic valve replacement was 10 percent, for mitral valve replacement 12.5 percent and for simultaneous replacement of two or three valves 25 percent. These figures must be viewed with the knowledge that the majority of the patients come from an indigent population with limited prior medical care and often with far advanced heart disease.

Certainly both survival rate and functional rehabilitation is compromised when operation is performed in a patient with severe pulmonary hypertension, myocardial fibrosis, a prior cerebral embolus with neurological deficit, cardiac cirrhosis, and advanced debilitation. Now that prosthetic valves are available which are structurally sound and have a low rate of peripheral emboli, it is justified to proceed with operation at an earlier stage in the patient's disease thus yielding a better chance for both survival and functional rehabilitation. Prosthetic valve replacement of irreparable valvular heart disease need no longer be considered a "salvage" operation to be used only in the desperately ill or moribund patient.

Bibliography

1. Starr, A. and Edwards, M.L.: Mitral Replacement: Clinical Experience with a Ball-Valve Prosthesis. *Ann. Surg.* 154:726, 1961.
2. McCord, C.W., Lui, A., Edwards, M.L. and Starr, A.: Aortic Valve Replacement: The Semirigid Self-Sealing Ball-Valve Prosthesis. *Surg. Forum* 13:213, 1962.
3. Starr, A., Edwards, M.L., McCord, C.W. and Griswold, H.E.: Aortic Replacement: Clinical Experience with a Semirigid Ball-Valve Prosthesis. *Circulation* 27:779, 1963.
4. Herr, R.H., Starr, A., Pierie, W.R., Wood, J.A. and Bigelow, J.C.: Aortic Valve Replacement: A Review of Six Year's Experience with Ball-Valve Prosthesis. *Ann Thor. Surg.* 6:199, 1968.
5. McGoon, D.C., Ellis, F.H., Jr. and Kirklin, J.W.: Late Results of Operation for Acquired Aortic Valve Disease. *Circulation* 31 (Suppl. 1): 108, 1965.
6. Herr, R. H., Kloster, F. E., Yukiyasu, S. and Starr, A.: Diagnosis of Management of "Ball Variance" Following Aortic Valve Replacement. *Circulation,* In Press.
7. *Personal Communication:* Edwards Laboratories, Inc. 1968.
8. Starr, A., Herr, R. H. and Wood, J. A.: Mitral Replacement: Review of Six Year's Experience. *J. Thorac. Cardiov. Surg.* 54:333, 1967.
9. Kloster, F. E., Herr, R. H., Starr, A. and Griswold, H. E.: Hemodynamic Evaluation of a Cloth Covered Starr-Edwards Valve Prosthesis. *Circulation,* In Press.
10. Kay, J. H., Tsuji, H. K., Redington, J. V., Kawashima, Y. and Kagawa, Y.: Experimental Mitral Valve Replacement with a New Disc Valve. *Ann. Thor. Surg.* 2:4, 1966.
11. Beall, A. C., Jr., Arbegast, N. R. and DeBakey, M. E.: *Concomitant Mitral and Tricuspid Valve Replacement.* Presented: American College of Surgeons, Clinical Congress, 1968.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of the Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. T[he] following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reacti[on] (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within th[e] recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in female[s] than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticaria type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-1E

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

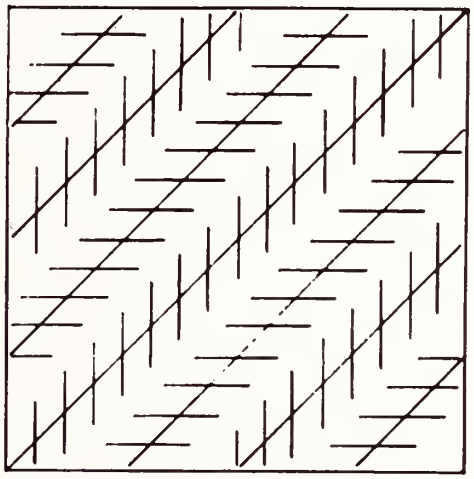
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

OPTICAL ILLUSION?



All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.

Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

SPECIAL ARTICLES

Blue Shield's Partnership with Medicine†

GEORGE DUNLOP, M.D.*

SOME years ago, two men graduated from the Medical School of the University of Louisville, both in the top 10 of their class. Each took graduate training and opened an office for the private practice of medicine.

During the years that followed, one of these physicians became involved in an increasing number of community affairs. He sat on a variety of committees that dealt with welfare problems, service organizations, school and public health programs. He learned to know business, labor, and government leaders in the community both socially and at a committee level. During what time that was left, he sat on state medical society committees, some involved with such subjects as ethics and professional fees. He watched the A.M.A.'s losing struggle to hold off a universal medicare program. He saw Blue Shield's evolving role in serving both the medical profession and the public. Drawing on his background of experience in the affairs of the community, and from his firsthand knowledge of the position of business, labor and government, he recognized the importance of Blue Shield's role in financing medical care. He became a staunch supporter.

Our second physician's interest led him down a different path. His practice in a specialty grew rapidly. He became interested in teaching and was appointed to the faculty of the medical school. As years passed, his spare time was taken up with a variety of research projects. His referred patients often represented difficult and complicated clinical problems. Because much of his time was taken up by teaching and research, his fees were considerably higher than those in the community. He attended few county or state medical society meetings. His contact with the community was peripheral. He knew little of the forces that were to change the profile of the practice of medicine. As a strong and independent individualist, he wanted to be left alone to practice and teach. He resented bitterly the encroachment of government and third parties on the practice of medicine. He was opposed to the Blue Shield program.

Now, as many of you have guessed, these men are both fictitious characters, but I dare say that their case history has been duplicated with some variations in every state of the union.

The position taken by the first physician represents by far the majority opinion or Blue Shield could never have prospered as it has. The minority group on the other hand, are often highly intelligent, dedicated men whose lives have been protected from the buffeting winds of change, and who are so submerged in their own work that they have little knowledge of the changes going on about them.

Now what are a few of the effects of public demand on the practice of medicine? Today, any effort is apt to be rewarded with success if it meets a public need. Markets are constantly being tested to find this out. We all remember the Edsel Ford. It has been the butt of many jokes over the years. Some of these jokes you may have forgotten, but there is one thing we all remember and that is that the Edsel Ford did not sell very well. It didn't do well because it wasn't what the public wanted.

In the early 1930's Blue Shield was limited to cash indemnity payments as a result of the position taken by the AMA. By the end of the decade, Blue Cross had four and one half million subscribers, whereas Blue Shield had about one hundred and seventy thousand. It must have been evident to a good many people that Blue Shield wasn't really offering what the public wanted.

During World War II when wages were frozen and medical services were becoming fringe benefits, the AMA gave official encouragement to the principle of direct payment to the physician for his services. Following this, Blue Shield expanded rapidly.

By the end of World War II, the pattern of medical practice began to change. The value of Blue Shield had been accepted by the public especially among the lower income groups, but as urban population began to expand and the cost of medical care began to go up, larger segments of the public began to feel the need for this form of coverage.

In the late 1950's the larger unions began negotiating agreements with management in which the entire cost of hospital and medical insurance for employees was involved. These unions began to fan out over the United States, across state borders creating

†Luncheon address delivered at closing session of 1969 Interim Meeting of the Kentucky Medical Association, March 27, Lexington

**President, Massachusetts Medical Service*

a demand for uniform benefits at a predictable cost. Blue Shield and the medical profession met this challenge in many areas by offering service benefits to under income families. The unions were articulate in spelling out their needs. Walter Reuther pointed this up when he stated: "Our goal has been to attain full service benefits in our health insurance program."

As utilization and costs of medical care began to climb, the public began to feel the need for more comprehensive coverage and the medical profession through Blue Shield made this available in many areas of the United States. However, the coverage was spotty and the benefits far from uniform. In some states, the medical leadership was not able to convince the physicians that service programs should be promoted and that indemnity payments were largely an expression of non-commitment on the part of the profession. These reluctant physicians had forgotten all about the Edsel car. They believed that they would continue to have a choice. They believed that they would continue to have a voice in their own affairs even if they operated outside the area of the public need. They did not believe as the Doctors Sommers of Princeton recently said: "Freedom to avoid the basic fact of change does not exist." What happened? Where the programs offered the public were adequate, the plans prospered, the public was pleased and the image of both the medical profession and Blue Shield was enhanced. The tax free status of the plan seemed justified, and no one could append the label of just another insurance company.

I don't mean to imply that physicians in those areas where only indemnity payments were offered weren't necessarily doing a statesmenlike job, or weren't sensitive to the public need. As individuals, many were accepting unrealistic indemnity payments as payment in full. This was their contribution to the public need. However, these well meaning physicians didn't seem to realize that a large percentage of the patients they were serving weren't paying for their Blue Shield premiums, and it was the big buyers, government, automobile, and rubber that were calling the terms. Although the intent to act responsibly may have characterized the doctors in these parts of the country, these good intentions could not be transferred on to a contract, and therefore in the eyes of the big buyers, didn't exist.

Now it is well to pause here and examine the unusual relationship that exists between Blue Shield and the medical profession. In representing the best interests of the public and the providers of medical care, Blue Shield speaks with an unbiased voice in its dealings with management, labor and government. Charges of conflicting interest are not easily raised against this association with its dual public responsibility. However, we have seen how ineffective Blue Shield can be without the full support of the doctors. On the other hand, the medical profession has through its relationship with Blue Shield an effective voice in its own affairs.

In brief then, at this point in time we had a situation where Blue Shield began to lag behind in meeting the public needs. The situation seemed frozen in the Blue Shield area, but the public represented by the big purchasers of medical care were beginning to move ahead, by-passing in some areas the Blue Shield plans. Government and management began to seek other intermediaries and to experiment with other methods of delivering health services. What is the evidence? HEW has made available federally insured mortgages to build and equip facilities for closed panel group practice. Philip R. Lee recently said: "We in Washington are frankly in a crusade to encourage the expansion of group practice." In New Haven, Connecticut, the Yale Medical School has brought in Isadore Faulk to set up a program financed by the A. F. of L. and C.I.O. to provide pre-paid medical services to a segment of the public. In Providence, Rhode Island, Brown University is considering a partnership with the unions whereby medical services will be offered through satellite hospitals on a pre-paid basis. In Boston, Jerome Pollack is drawing up with the Harvard Medical School a plan which encompasses the construction of a health center, served by members of the staff of the Peter Bent Brigham and Beth Israel Hospitals. This medical staff will be on salary and offer comprehensive medical services to some 30,000 employed members of industry concentrated in an area with a radius of 10 miles.

Columbia, a new town located mid-way between Baltimore and Washington with a population of 3.000, is expected to set up a form of practice financed by the Connecticut General Life Insurance Company and serviced by the faculty of the Johns Hopkins Medical School. This community is expected to eventually increase to 25,000 with about 30,000 eligible residents in the surrounding area. Robert Heyssel, M.D., director of the Hopkins Health Care Program, was quoted as estimating the cost of the plan for a family of three at about $45 a month.

This list of examples of what has been happening where the big buyers of medical services cannot find what they want on the Blue Shield shelf could go on and on, but I know you all see the point.

The tide of events has permanently interjected a third party between the physician and the patient because the patient can no longer finance medical services. Many doctors do not seem to realize that these large purchasers of medical care have written the cost of medical services into almost every product we buy today, and that doctors and hospitals are woven into the very fabric of our economy. When a hospital board of trustees increases the daily cost of a bed, or a committee of the state medical society increases the medical fee schedule, the cost of manufacturing an automobile may go up.

I think that it can unequivocally be stated that the public wants paid in full programs at a predictable cost with effective control. The purchasers of medical services today will buy these from the Blue Shield medical team if they are available. If not, government, the medical schools, or the unions themselves will set up their own programs and are already in the business. The AMA is not in a position to solve these problems of financing medical care because in the eyes of the public, any association made up of

physicians alone is faced with a conflict of interest when dealing in money matters.

Blue Shield on the one hand must sell its contracts in the open market, offering a product that is not only reasonable, but attractive to the public buyer. On the other hand, Blue Shield has the responsibility of representing the positions of the providers of medical care and seeing that their interests are equally well represented.

During the more recent years, as the economy expanded, the medical profession and the purchasers of medical care became disenchanted with fixed fee schedules, indemnity programs, and income limits. Blue Shield, with its ear to the ground, recognized this and began to promote usual and customary fees for the large groups. Although such programs resulted in a 30 percent increase in premium rate (in Kentucky almost 100%), in many instances business, labor and government were willing to absorb this added expense because more than anything else they wanted full coverage at a predictable cost. The program is popular and selling well, demonstrating the fact that there is no combination more effective than the joining together of those who can provide medical services with those who can finance it as we have in medicine's partnership with Blue Shield. Some union officials are not concerned about the success or failure of the joint effort of the profession and Blue Shield because they believe that the system will eventually collapse from overcharges and that closed panels or the federal government will take over. Most of us do not share this opinion.

Blue Shield is in a strategic position to influence the course of a number of fundamental decisions that will be made during the next five or 10 years regarding the organization and delivery of health care. This will be true even though it is a certainty that many of these decisions will be made as legislation is passed and contracts written.

Blue Shield's strength in serving the profession evolves from a number of factors. It is one of the few national organizations intimately concerned with the medical power structure in so many communities, states and regions. The tremendous weight and size of our existing coverage will be taken into account in any consideration of medical financing. These plans will have the most advanced, if not the only, capability in many areas of control such as utilization review, profiles of professional charging, and unlimited medical advisory committees to evaluate the expanding medical technology.

Blue Shield should be in a position to guide local state and federal groups away from some of the more extreme suggestions. Blue Shield, as never before, has a background of experience in the financing of health care and is developing a tradition of impartiality in dealing with both the purchasers and providers of medical care.

Time is running out and we of the medical profession must decide whether we will find ourselves locked into a federal fee schedule or to a more flexible Blue Shield plan in which we have an active voice in our own affairs.

Blue Shield's position will be untenable if it lacks proper controls. One of the most tragic abuses that could undermine any paid in full program is the practice of a physician making a supplementary charge over and above the usual and customary fee. Such a practice will be unacceptable to the public and it is Blue Shield's responsibility to remind the medical profession of this fact. This partnership between Blue Shield and the profession must demonstrate to the purchasers of medical services that our product is better than anything government can offer, and that the medical profession will accept self-imposed controls on fees and utilization, and that above all, they will continue to concern themselves with quality control. Blue Shield can respond with the mechanisms for paying for medical care, but without the support of the full team, will get nowhere. Blue Shield and medicine must not be bypassed in medical care planning. Blue Shield's most effective weapon lies in its capacity to explain to the medical profession the market needs of the public, and to join with the doctors in planning and financing programs which will meet these needs.

The Blue Shield plan here in Kentucky is growing in strength and effectiveness from day to day due to the continuing cooperation of the state medical society. Nationwide, as in Kentucky, the future rests on the effectiveness of our joint efforts.

EDITORIALS

Learning Centers

ONCE a physician establishes himself in the private practice of medicine he is apt to find himself a very busy man. His is not likely to be a 40-hour week but often one of 60 hours or more depending somewhat on where he practices and the nature of his practice. This kind of work schedule develops because of the demand for medical care by the public and the relative shortage of physicians in some areas. The demands on his time do not terminate at the end of his working day. His family needs and deserves time and attention. It is the experience of most established physicians to be asked to join and participate in the affairs of churches, civic groups, parent-teacher organizations, political parties, voluntary health agencies and many clubs, societies and organizations—all of this in addition to the participation in local and sometimes state and national medical organizations.

Even though the physician attempts to use his time wisely and to the best advantage, he finds himself a busy man and sometimes without the time to do some of the things that he would like to do or should do. In the midst of all of this, he wants to continue his medical education and to enjoy the feeling that he is providing his patients with excellent medical care. Keeping up with medical education is no easy matter. In this day of good science reporters and versatile communication systems the patient or his family may hear of a new medication or medical development before the physician does.

There is no lack of medical journals to subscribe to or medical meetings the physician may travel to, but in his hometown there is an institution which remains in most instances virtually undeveloped as a learning center. This is the community hospital in which he practices. Aside from case studies and discussions at the monthly staff meetings and the customary committee meetings, opportunities and facilities for individual study are often limited.

In a recent issue of *The New England Journal* (February 27, 1969), a study of the libraries of 40 community hospitals in the New England area was reported. The weaknesses of these libraries were inadequate collections, inadequate personnel, inadequate space and the absence of any practical indexing system to facilitate use of collections that do exist. These kinds of problems can be corrected. Observation indicates that hospital libraries of poor quality are not used by the staff, but if the library is improved it receives increased use by the staff. A community hospital need not confine its efforts to the concepts of a conventional library. The conventional library remains the core of the hospital learning center. The learning center can include filmstrips, teaching tapes on a wide variety of subjects, slide collections, exhibits and records. All or part of these can be added to the library to convert it into a community hospital learning center which is easily available to the practicing physician.

Hospital learning centers could be brought into being in community hospitals if this method of continuing medical education would attract the interest of staff physicians, hospital administrators, hospital trustees and professional organizations that already have an established interest in the medical education area.

WALTER S. COE, M.D.

ORGANIZATION SECTION

Distinguished Guest Speakers To Appear on Scientific Program Of KMA Annual Meeting September 23-25 in Louisville

Sixteen prominent guest speakers have accepted invitations to participate in the scientific program of the 1969 Annual Meeting of the Kentucky Medical Association, September 23-25 at Convention Center, Louisville. The guest physicians will speak on a variety of timely medical topics at the four general sessions and each will participate in the program of the specialty group in his field.



Doctor Fuste

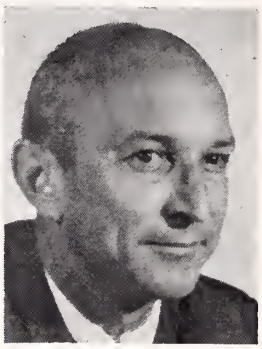
Some of the themes chosen for the general session panel discussions and individual presentations are "Cancer," "Drugs," "Transplants," and "Obesity." Moderators of panels will include Benjamin F. Rush, M.D., Lexington; George W. Pedigo, M.D. and Beverly T. Towery, M.D., Louisville.

In addition to the scientific sessions and meetings of 16 specialty groups, the Annual Meeting will feature meetings of the KMA House of Delegates, scientific and technical exhibits, the President's Luncheon, an Orientation Program for new members, and meetings of the Woman's Auxiliary to KMA.

Participating in a discussion of "New Trends in Chemotherapy" at the first general session will be Ricardo Fuste, M.D., Memphis, Tenn., guest of the Kentucky Chapter, American College of Radiology; M. Eugene Lahey, M.D., Salt Lake City, Utah, guest of the Kentucky Chapter, American Academy of Pediatrics; Willet F. Whitmore, Jr., M.D., New York, N.Y., guest of the Kentucky Urological Association; and Richard K. Winkelmann, M.D., Rochester, Minn., guest of the Kentucky Dermatological Society.

Doctor Fuste, a radiotherapist at Methodist Hospital, Memphis, graduated from the University of Havana, Cuba Medical School in 1941. Before coming to the United States in 1961, he was engaged in private practice of surgical pathology and radiotherapy for 18 years in Havana.

A 1943 graduate of St. Louis University School of Medicine, Doctor Lahey is head of the department of pediatrics at the University of Utah and a member of the AMA Residency Review Committee for Pediatrics. He is a past president of the Western Society for pediatric research and a member of the editorial board of *The Journal of Pediatrics*.



Doctor Lahey



Doctor Whitmore

Doctor Whitmore graduated from Cornell University Medical College in 1942 and is now clinical professor of surgery at that institution. He is a member of numerous medical societies and serves as a consultant to St. Albans Naval Hospital and the National Cancer Institute.

A member of the Mayo Clinic staff since 1956, Doctor Winkelmann is professor of dermatology and anatomy at the University of Minnesota. He received his M.D. degree from Marquette University in 1948 and his Ph.D. in dermatology at the University of Minnesota in 1956.

Additional program details will be released in forthcoming issues of *The Journal*.

Seven Trustee Districts To Meet During May and June

Seven KMA Trustee Districts will hold their annual meetings during May and June, according to the trustees for the districts. At each meeting KMA President Henry B. Asman, M.D., Louisville will be the featured program speaker. Doctor Asman plans to discuss Association activities in a carefully prepared slide presentation.

At press time the Eleventh District had planned to meet May 15 at the Madison Country Club, Richmond. Appearing with Doctor Asman will be Hugh Mahaffey, M.D., Richmond, who will discuss "Medicine in Moscow." Doctor Mahaffey recently attended a medical science tour in Russia.

Meetings of the Thirteenth and Fourteenth Districts, announced in the March issue of *The Journal*,

have been changed to May 28, Ashland, and May 29, Pikeville, respectively. The Third District will meet May 22 in Princeton.

Other scheduled District Meetings include the Ninth on June 4 in Paris, the Second, June 10 in Owensboro, and the Twelfth on June 11 in Somerset. Physicians in each District planning a meeting will receive pertinent information and reservation cards in advance of each session.

AMA To Hold 118th Convention In New York July 13-17

Color television, medical motion pictures, 300 scientific exhibits, general sessions and panel discussions will be among the many features highlighting the 118th Annual Convention of the American Medical Association July 13-17, in New York, N.Y. Most of the convention activity will be centered at the Coliseum and the New York Hilton Hotel. The House will meet at the Americana Hotel.

The four general scientific sessions will be on the topics of Human Sexuality, Physical Fitness and Aging, Impact of Medical Education on Patient Care, and Chronic Pulmonary Insufficiency and Air Pollution Problems.

Six sessions on special topics have been scheduled. These will include Drug Utilization, Mental Health, Disaster Planning, Neurological Surgery, Nuclear Medicine and Plastic and Maxillofacial Surgery.

Convention news, interviews, panels and scientific presentations will once again be programmed on television for benefit of physicians who wish to view the events in their own rooms in many of the nearby hotels and motels. AMA President Dwight L. Wilbur, M.D., urges all physicians to make their plans and reservations now for this exciting meeting.

Mr. Spangler Named To Head Ky. Public Health Assn.

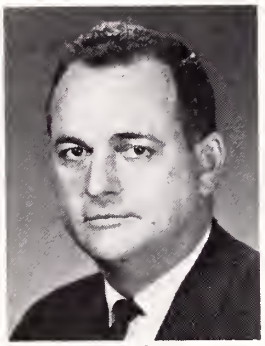
Phillip R. Spangler, Louisville, assistant public health director in the Office of Local Health, Frankfort, was named president-elect of the Kentucky Public Health Association during its annual meeting March 31-April 2 at the Seelbach Hotel, Louisville. Mr. Spangler succeeds William S. Wester, Frankfort, who was installed as president.

Highlights of the three-day session included an address by Dwight L. Wilbur, M.D., San Francisco, Calif., president of the American Medical Association, and sectional meetings on various aspects of health care.

Mr. Spangler received his M.P.H. degree from the University of Michigan in 1961. Before joining the Office of Local Health in 1958, he was active in the Venereal Disease Control Program of the U.S. Public Health Service for the state of Kentucky and instrumental in assisting county health departments in the operation of these programs.

Ky. Dentists Name Dr. Logan President-Elect at Meeting

Theodore E. Logan, D.M.D., Louisville, was named president-elect of the Kentucky Dental Association during its 109th Annual Session, March 30-April 2 at the Brown Hotel, Louisville. Doctor Logan succeeds J. M. Downing, D.M.D., Tompkinsville, who was installed as president during the meeting.



Doctor Logan

During the four-day session, participants heard luncheon addresses by H. A. McGuirl, D.D.S., Providence, R.I., president of the American Dental Association, and Merritt Dietz, Kentucky's Commissioner of Economic Security. Other highlights included scientific sessions, exhibits, reports and the President's Banquet.

A 1949 graduate of the University of Louisville School of Dentistry, Doctor Logan is professor and chairman of the School's department of prosthetic dentistry. He is a past president of the Louisville Dental Society and a member of the American College of Dentists, American Prosthodontic Society and the Governor's Advisory Committee on Medical Assistance.

AMA President Visits KMA Office

Dwight L. Wilbur, M.D., San Francisco, Calif., president of the American Medical Association, visited with KMA officers and AMA delegates at the Headquarters Office in Louisville April 2. Doctor Wilbur was in the city to address the Kentucky Public Health Association during its annual meeting. He was accompanied by Edward A. Uzemack, director of the AMA Communications Division's Officers Services Department.

CORRECTION

In the March issue of *The Journal* in the article entitled "County Societies Name Officers for 1969 Associational Year," the following names were omitted from the list of KMA delegates from Fayette County. *The Journal* regrets the omission.

Richard D. Floyd, M.D., Lexington
Richard F. Hench, M.D., Lexington
Bush A. Hunter, M.D., Lexington
Carl H. Scott, M.D., Lexington
Ben C. Stigall, M.D., Lexington

Record Attendance Reported At 1969 Interim Meeting

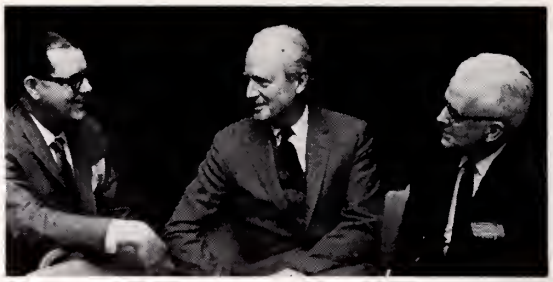
A record attendance of 336 physicians, their wives and guests attended the 1969 KMA Interim Meeting March 26 and 27 at the Continental Inn, Lexington. The previous attendance record was set at the 1966 meeting when a total of 261 were registered.

A highlight of the two-day session was an address by Governor Louie B. Nunn at the opening dinner meeting March 26. Governor Nunn presented an overall picture of health problems throughout the state and expressed a desire to work with members of the Association in solving them.

A panel discussion of Comprehensive Health Planning, moderated by George F. Brockman, M.D., Greenville, immediate past president of KMA, was featured on the March 27 morning program. Participants included Dale Farabee, M.D., Kentucky's Commissioner of Mental Health, Frederick A. Stine, M.D., Ft. Thomas, and Strawn Taylor, Frankfort. The panel members explained the development and purpose of the CHP Program in Kentucky and suggested ways in which physicians may participate in its successful operation.

Also featured on the program were Donald E. Wood, M.D., Indianapolis, Ind., who discussed Health Manpower problems, and Norman E. Farber, New York, N.Y., who explained the operations of the National Health Council's Health Careers Program of which he is director. A luncheon session featuring a discussion of the profession's relationship with Blue Shield, by George Dunlop, M.D., Boston, Mass., closed the meeting.

Termed highly successful by KMA President Henry B. Asman, M.D., Louisville, the meeting also included KMA's Eighth Orientation Program for new members and meetings of the Woman's Auxiliary and the KMA Board of Trustees. In 1970 the session will be held April 15 and 16 at Barkley Lake Lodge.



Walter L. Cawood, M.D., Ashland, KMA President-Elect (left) and KMA President Henry B. Asman, M.D., Louisville (right) chat with George Dunlop, M.D., Boston, Mass. preceding Doctor Dunlop's luncheon address closing the 1969 Interim Meeting. Doctor Dunlop, president of Massachusetts Medical Service, discussed "Blue Shield's Partnership with Medicine."

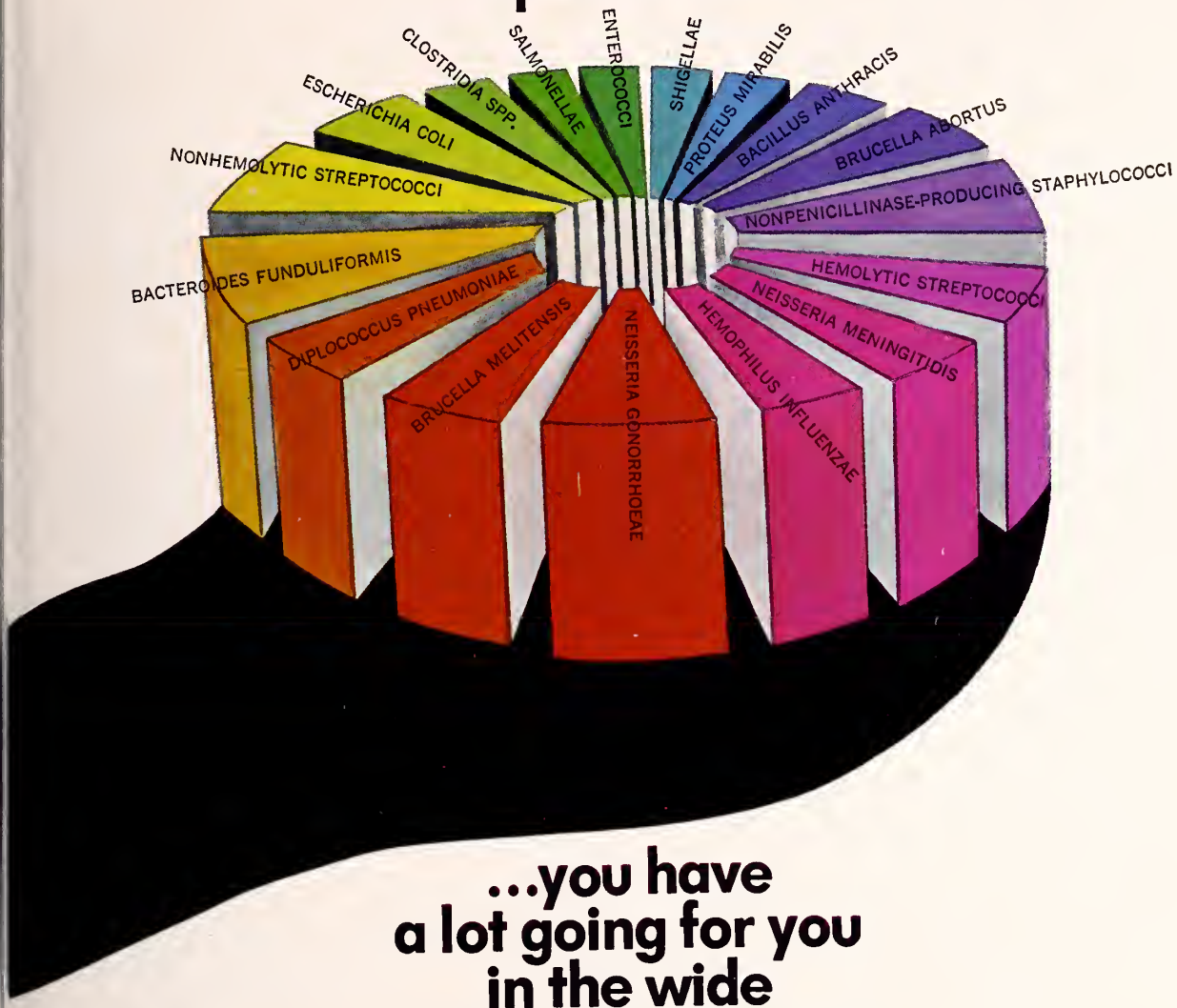


Following their presentations on the 1969 Interim Meeting program, Donald E. Wood, M.D., Indianapolis, Ind. (left) and Norman E. Farber, New York, N.Y. (right) talk with KMA President Henry B. Asman, M.D., Louisville, who presided at the morning session. Doctor Wood discussed health manpower problems and Mr. Farber outlined the activities of the Health Careers Program of the National Health Council.



KMA President Henry B. Asman, M.D., Louisville (right) introduces panelists who discussed "Comprehensive Health Planning" at the March 27 session of the 1969 Interim Meeting. The participants, from left to right, are Dale Farabee, M.D., Kentucky Commissioner of Mental Health; Strawn Taylor, director of Comprehensive Health Planning; Frederick A. Stine, M.D., a member of the State Health Planning Council; and George F. Brockman, M.D., KMA past president, who served as moderator.

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

now she can cope...



thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

ublic Enema No.1





n the rewards of sparing your patients the tubes
ribulations of unpleasant enemas.

pared to enemas, Dulcolax suppositories are a
ler and simpler way to empty the bowel. Gone
he tubing, the "accidents", and the bruised egos.
one suppository, inserted against the bowel wall,
lly brings about an evacuation within 15 minutes
hour.

e hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-6118

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48166



118th Annual Convention

AMA

NEW YORK CITY

JULY 13-17, 1969

The magnetism and the grandeur that characterizes New York City will provide a superb setting for AMA's 118th Annual Convention in July. Plan to attend now and look forward to five memorable and stimulating convention days in a city of unlimited excitement.

Continue your postgraduate education with a varied program of • four General Scientific Meetings on Chronic Pulmonary Insufficiency and Problems of Air Pollution, Human Sexuality, Impact of Medical Education on Patient Care, and Physical Fitness and Aging • 23 Section Programs • Color Television • Medical Motion Pictures • and over 700 scientific and industrial exhibits. The nation's outstanding medical authorities will lecture and discuss the significant advances in today's medicine.

In addition the AMA TV network will present more than 40 hours of convention programming.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, July 16, 1969. Since space is limited, we suggest you make your reservations before June 30, 1969. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 26, 1969.

NEW YORK CITY, NEW YORK • JULY 13-17, 1969
AMERICAN MEDICAL ASSOCIATION'S 118th ANNUAL CONVENTION

Digest of Proceedings, Board of Trustees

March 26, 1969

The fourth meeting of the Board of Trustees was held on March 26 in conjunction with the KMA Interim Meeting in Lexington. The session opened with the presentation of routine reports. The 1969-70 fiscal year budget, presented by Budget Committee Chairman Rex Hayes, M. D., was adopted.

Actions taken at the March 12-13 Executive Committee meeting were reported for information. These included KMA's official position regarding tuberculosis in Kentucky and the status of the TB hospitals. The Board requested the establishment of a task force to plan for the eradication of tuberculosis in this state. Other items reported were KMA's position regarding the composition and duties of the State Board of Health, and approval of a special project to train clinical associates at the University of Kentucky.

James Sammons, M. D., chairman of the AMPAC Board of Directors, was then recognized for a detailed report on AMPAC's activities. Discussion was held on the recent HEW report on chiropractic as well as the plans of the Cults Committee to disseminate this material. The Hospital Committee received approval for KMA policy on the full-time staffing of hospital emergency rooms, and action was taken on recommendations submitted by the Ad Hoc Committee on Insurance Forms to modify the procedure of completing forms demanded by "weekly" insurance policies.

Two matters recieved a full and lengthy discussion, one being possible conflicts between county medical society bylaws and KMA Bylaws, especially in the area of membership classifications. This problem was referred to the Constitution and Bylaws Committee for study and recommendations. Adoption of the "Usual and Customary" program by the House of Delegates in September brought forth numerous questions in its implementation. This matter was referred back to the Advisory Committee to Blue Shield for the purpose of presenting a definitive proposal for clarification.

KMA President Henry B. Asman, M. D. presented a full report on Title XIX in Kentucky to include the purpose of and progress being made in numerous recent meetings he has held with state and federal government officials. The president stated that further meetings would be held in the immediate future.

An official statement was approved noting KMA's endorsement of Comprehensive Health Planning. Motions were approved allocating $5 of each KMA member's dues as the subscription rate to the KMA Journal while the non-member rate would be $10, and authorizing legal counsel to file a brief in court relating to a decision involving the doctrine of Res Ipsa Loquitur.

It was reported that a letter had been written to the AMA supporting the candidacy of Carroll Witten, M. D., for membership on the AMA Council on Medical Service. A matter concerning Kentucky's narcotic control program was delayed pending further information.

The meeting closed with the Board accepting an invitation to hold the 1970 Interim Meeting at the new Barkley Lake Lodge on April 15-16.

Fifty-seven Physicians Attend Spring Orientation Program

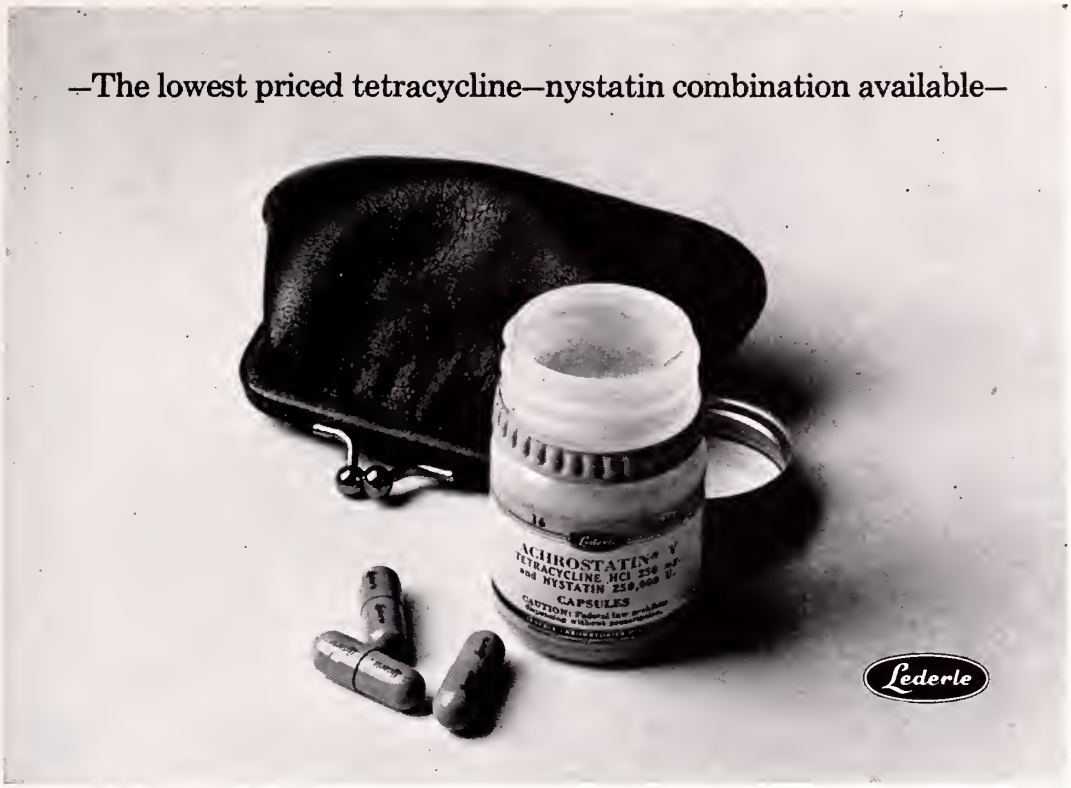
N. L. Bosworth, M.D., Lexington, chairman of the Committee on Communication and Health Education has reported that 57 physicians attended the Eighth KMA Orientation Program for new members March 26 in Lexington during the Interim Meeting.

The next Orientation Session is scheduled to begin at 8:30 a.m., September 22, in the Mirror Room of the Kentucky Hotel, just prior to the opening of the 1969 Annual Meeting. Program details will be carried in the August issue of *The Journal.*

The names of the physicians who attended the March 26 program are listed below. If you attended the session and your name has been inadvertently omitted, please contact the KMA Headquarters Office.

Murray F. Ables, M.D., Lexington
Frank M. Alfano, M.D., Louisville
Billy F. Andrews, M.D., Louisville
William J. Bechmann, M.D., Florence
Gordon D. Betts, M.D., Somerset
H. Martin Blacker, M.D., Lexington
William N. Blalock, M.D., Paducah
T. R. Bryant, Jr., M.D., Lexington
Jerry M. Bryson, M.D., Harlan
Donald M. Buckner, M.D., Louisville
Thomas Buie, M.D., Lexington
Richard W. Carpenter, M.D., Morehead
Angelo A. Ciliberti, M.D., Louisville
G. Nelson Copeland, Jr., M.D., Lexington
Terry L. Davis, M.D., Bowling Green
Ronald W. Dunbar, M.D., Lexington
Peter Alan Emmett, M.D., Wilmore
John W. Garden, M.D., Lexington
Gary D. Givens, M.D., Central City
John L. Geiser, M.D., Lexington
James G. Gully, M.D., Madisonville
Charles M. Hargadon, M.D., Louisville
Gordon Hollins, M.D., Harlan
John P. Howard, M.D., Louisville
Harry B. Huntsman, M.D., Greensburg
J. Barrett Hyman, M.D., Louisville
Octavius E. Iglesias, M.D., Lexington
Yung Kook Im, M.D., Ludlow
Albert G. Izquierdo, M.D., Erlanger
Chris S. Jackson, Jr., M.D., Danville
H. Douglas Jameson, M.D., Lexington
Jean Kawerk, M.D., Fort Thomas
Frank R. Lemon, M.D., Lexington
Darrell Dean Life, M.D., Beverly
David H. Looff, M.D., Lexington
Reginald S. Lowe, M.D., Middlesboro
V. Wayne Lowe, M.D., Madisonville
Michael P. McQuillen, M.D., Lexington
Sidney G. Marcum, M.D., Louisville
Frank G. Marsh, M.D., Lexington
William R. Merritt, Jr., M.D., Lexington
Joe A. Nichols, M.D., Cynthiana
Paul L. Odom, M.D., Elkhorn City
George R. Park, M.D., Lexington
Emanuel H. Rader, M.D., Pineville
Garner E. Robinson, M.D., Ashland
Robert F. Sexton, M.D., Louisville
Archibald F. Shuler, M.D., Madisonville
John F. Simonds, M.D., Louisville
Thomas Stephenson, M.D., Louisville
James L. Stevenson, M.D., Brooksville
John G. Stober, M.D., Louisville
John C. Tomlinson, M.D., Louisville
Russell L. Travis, M.D., Lexington
H. M. Vandiviere, M.D., Lexington
Frank Whalen, Jr., M.D., Harrodsburg
Mary Woodring, M.D., Whitesburg

—The lowest priced tetracycline—nystatin combination available—



HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-253-2761

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

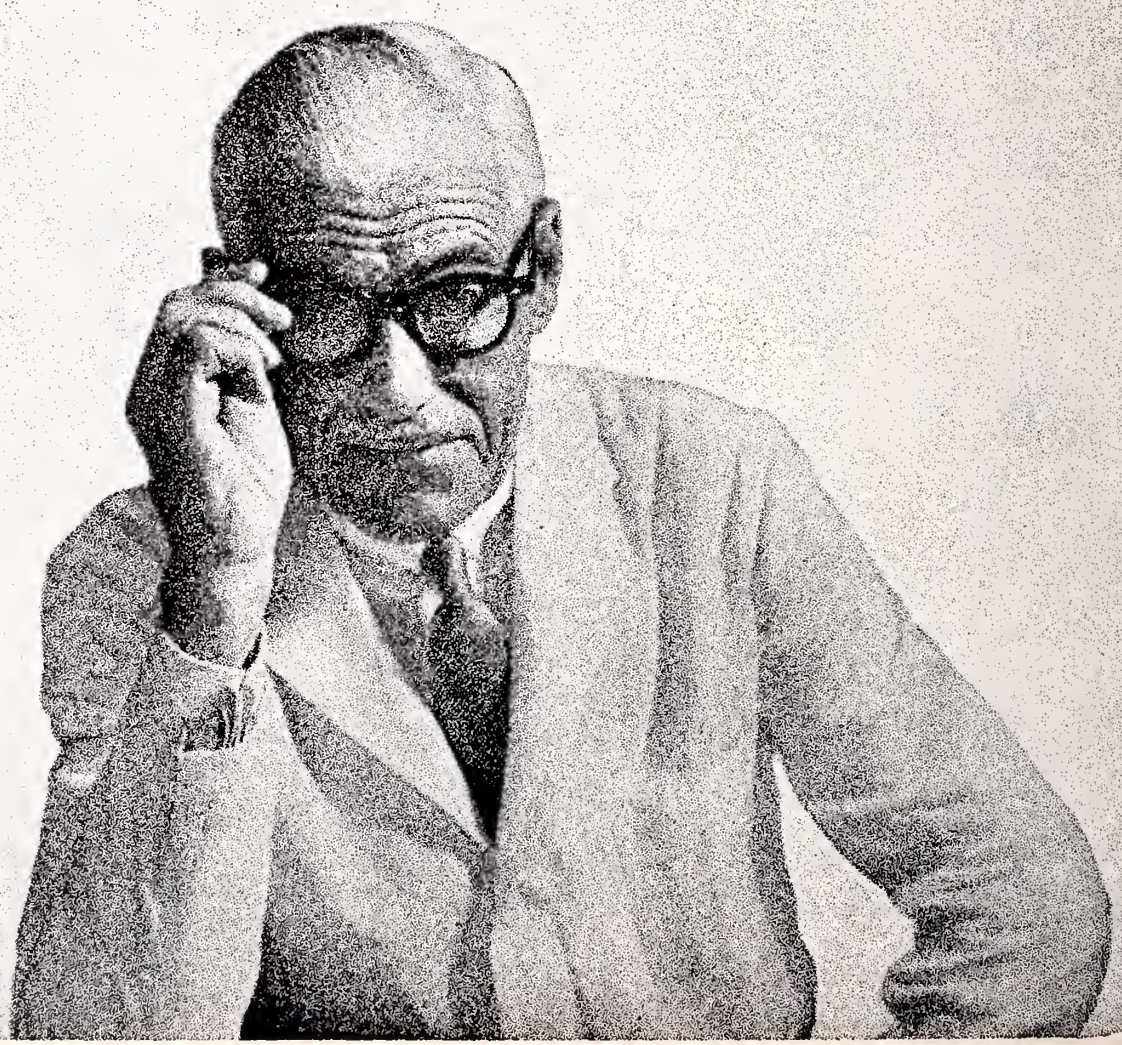
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



Diabetic Children's Camp Set

The Kentucky Diabetes Association has planned its fourth annual summer camp for diabetic children August 3 to 16 at Camp Daniel Boone near Lexington, according to R. J. Alberhasky, M.D., Louisville, Camp Committee member.

All Kentucky physicians treating diabetic children are urged to make this information available to their patients. Details may be obtained from The Kentucky Camp for Diabetic Children, Fincastle Building, Louisville, Ky. 40202.

In Memoriam

OSCAR L. BARNES, M.D.
Hopkinsville
1882-1969

Oscar L. Barnes, M.D., 86, a retired physician who had practiced in the Hopkinsville area for 50 years, died March 19 at the Jennie Stuart Hospital after a long illness. Doctor Barnes was a 1909 graduate of the University of Louisville School of Medicine.

J. B. LYEN, M.D.
Lawrenceburg
1871-1969

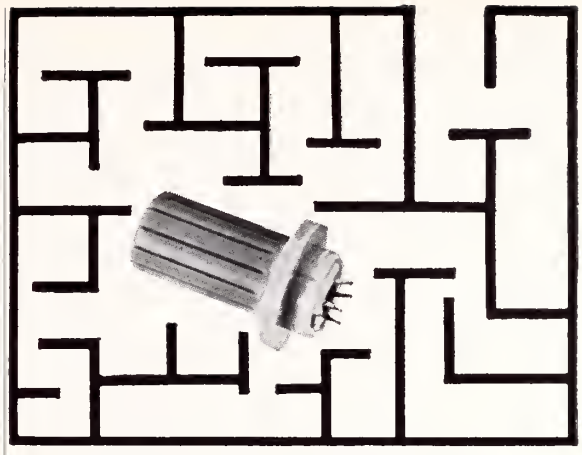
J. B. Lyen, M.D., 98, who had practiced in Lawrenceburg and in California for more than 50 years, died April 3 at King's Daughters Hospital, Frankfort. Doctor Lyen was an 1894 graduate of the University of Louisville School of Medicine.

THOMAS A. SHANNON, M.D.
Lexington
1874-1969

Thomas A. Shannon, M.D., 95, a Lexington physician for 62 years, died March 8 at St. Joseph Hospital. A 1906 graduate of the University of Louisville School of Medicine, Doctor Shannon served on the Fayette County psychiatric board from 1945 until his retirement in 1967. He continued to practice on a part-time basis after his retirement.

J. CAMPBELL THOMPSON, M.D.
Lexington
1895-1969

J. Campbell Thompson, M.D., 73, a retired Lexington physician, died March 20 at the Veterans Administration Hospital. A 1916 graduate of the National University of Arts and Sciences at St. Louis, Doctor Thompson had practiced in Lexington for 42 years.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

AN
ETHICAL
AND
EFFECTIVE
COLLECTION
SERVICE

SPECIFICALLY DEVELOPED
FOR THE
MEDICAL PROFESSION

Professional Service Co.

93 MASSACHUSETTS AVENUE
BOSTON, MASSACHUSETTS 02115

KMA Committee Reports

McDowell House Board of Managers

Laman A. Gray, M.D., Louisville, Chairman

Danville, Kentucky **March 12, 1969**

The McDowell House Board of Managers held its third meeting this year on March 12 at the McDowell House in Danville. The Board of Managers heard a detailed explanation of the proposed McDowell House budget for 1969-70 and discussed methods of stimulating more people to visit the House.

Other items considered by the Board were a progress report on the installation of the new air conditioning system for the House, and plans for this year's summer tourist season.

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **March 20, 1969**

The KMA Hospital Committee recently held its second meeting of the year with the full time staffing of hospital emergency rooms as the primary agenda item.

The committee members reviewed the current staffing methods utilized by various hospitals, discussed the ethical staffing principles as set by the KMA Judicial Council and recommended overall emergency room staffing guidelines to the KMA Board of Trustees.

A discussion was held on the 24th "Dry Run" Team Accreditation visit made during February and plans were set for the 25th visit. May 29 is the tentative date for the next meeting.

Community and Rural Health Committee

Ralph D. Lynn, M.D., Elkton, Chairman

KMA Headquarters Office **March 20, 1969**

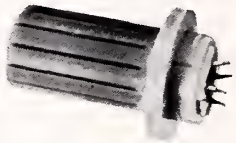
The KMA Community and Rural Health Committee met recently and made plans for the promotion of Immunization Week, May 4-10. The Committee plans to coordinate Immunization Week with Community Health Week in 1970.

The Committee heard reports on the other areas of its responsibility which include mental health, TB and highway safety.

Actions taken by the Committee include introduction of a resolution on the Slow Moving Vehicle Emblem to the KMA House of Delegates, and plans to invite a representative from the Mental Health Council of the American Medical Association to its next meeting.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

Primary Inguinal Hernia Repair

(Continued from page 351)

2. McVay, C. B.: Preperitoneal hernioplasty, *Surg. Gynec. & Obst.* 123: 349, 1966.

3. Nyhus, L.M. and Harkens, H.N.: *Hernia.* J. B. Lippincott Co. Philadelphia and Montreal. 1964.

4. Dyon, W.L. and Pierce, W.S.: Changing concept of inguinal herniorrhaphy. *Arch. Surg.* 91: 971, 1965.

5. Read, R. C.: Preperitoneal Exposure Inguinal Hernia. *Current Probems in Surgery.* Year Book Medical Publishers, Inc. Chicago. Oct., 1967: p. 17.

6. Andrews, E.: A method of herniotomy utilizing only white fascia. *Ann. Surg.* 80: 225, 1924.

7. Harkins, H. W.: Repair of groin hernias. Progress in past decade. *S. Clin. North America* 29: 1457, 1949.

8. McVay, C.B. and Anson, B.J.: Inguinal and femoral hernioplasty. *Surg. Gynec. and Obst.* 88: 473, 1949.

9. Halsted, W.S.: The radical cure of hernia, *Bull. Johns Hopkins Hosp.* 1: 12, 1889.

10. Bassini, E.: Sopra 100 casi di cura radicale dell'ernia inguinale operata col metodo dell'autore. *Arch. atti soci, ital. chir.* 5: 315, 1888.

11. Palumbo, L.T. Paul, R.E. and Emery, F.B.: Results of primary inguinal hernioplasty. *A.M.A. Arch. Surg.* 64: 384, 1952.

12. Palumbo, L.T., Paul, R. E. and Mighell, S.J.: Primary inguinal hernioplasty: A study of 1375 cases. *S. Clin. North America* 34: 567, 1954.

13. Palumbo, L.T., Sharpe, W.S., Hunter, R. D., and Berardi, R.S.: Primary indirect inguinal hernioplasty: Results in 2595 operations. *S. Clin, North America* 43: 1439, 1963.

14. Artz, C.P. and Hardy, J.D.: *Complications in Surgery and their Management.* W.B. Saunders Co. Philadelphia and London, 1960. p. 861.

NEWS ITEMS

Charles E. Richardson, M.D., an internist specializing in cardiology, is practicing in association with the Graves-Gilbert Clinic in Bowling Green. Doctor Richardson graduated from the University of Tennessee Medical School in 1964 and completed his internship and residency training in University of Tennessee and Memphis city hospitals.

Donald B. Katz, M.D. has opened an office in Louisville, limiting his practice to obstetrics and gynecology. A 1962 graduate of the University of Louisville School of Medicine, Doctor Katz completed his internship at Louisville General Hospital and his residency training at the University of Pittsburgh.

Samuel G. Bell, M.D., an internist, is practicing in association with John C. Quertermous, M.D., in Murray. Doctor Bell graduated from the University of Tennessee Medical School in 1958 and completed his internship and residency training in Memphis hospitals. He practiced previously in Birmingham, Ala.

Frank R. Lemon, M.D., a specialist in preventive and internal medicine, is a full-time faculty member in the University of Kentucky College of Medicine. A 1950 graduate of Loma Linda University Medical School, Doctor Lemon has practiced previously in Wyoming and California.

Lee R. Chutkow, M.D., a psychiatrist, is practicing in association with Arthur Daus, M.D., in Louisville. A 1954 graduate of the University of Colorado Medical School, Doctor Chutkow practiced previously in New Jersey and New Mexico.

Jerry C. Sutkamp, M.D., a general practitioner, has opened an office in Bellevue. A 1963 graduate of the University of Louisville School of Medicine, Doctor Sutkamp recently completed four years of service as a flight surgeon in the U.S. Navy.

Victor J. Magary, M.D., an obstetrician and gynecologist, is practicing in association with Lawrence Hiltz, M.D. and Joseph Molony, M.D., in Covington. Doctor Magary graduated from St. Louis University Medical School in 1960 and completed his residency training at the University of Minnesota following his internship at St. Joseph's Hospital, St. Paul, Minn.

Charles R. Rogers, M.D., is practicing in association with Okey H. Sanford, Jr., M.D., in Ashland. Doctor Rogers graduated from the University of Kentucky College of Medicine in 1967 and completed his internship and residency training at St. Joseph's Hospital, Phoenix, Ariz.

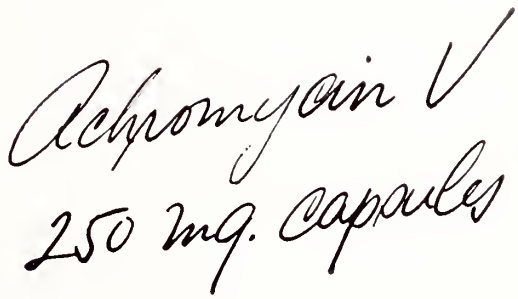
Richard Wham, M.D., a radiologist, is practicing in association with John Marchand, M.D. at Community Methodist Hospital in Henderson. A 1958 graduate of the University of Illinois Medical School, Doctor Wham practiced previously in Akron, Ohio.

DOCTOR SUITE AVAILABLE

Excellent Opportunity
In Highly Populated
Shively Area

Modern, 10-room suite with air conditioning, carpeting, on second floor; elevator, private and public restrooms, Heatherfield Center on Crums Lane. Owner will sacrifice.

Call 447-5483
448-1691



ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481D-9

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665.....President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660....Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123.....Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661.....Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211.....Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282.....Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552..Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340.....1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255.....1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362..1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231.....1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406.....1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751.....1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155....1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698.....1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357.....1969

Buyers Guide

MAY BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Cancer Society 376
American Medical Association 373

Bristol Laboratories 321, 369
Burroughs Wellcome 330

Campbell Soup 357

Doctor Suite 379

Geigy Pharmaceuticals 328-329, 334-336, 371
General Leasing Corporation 337

Highland Hospital 375
Hynson, Westcott & Dunning 317

Lederle Laboratories 319, 375, 377, 378, 379
Lilly, Eli & Company 342

McNeil Laboratories 370
Medical Protective Company 361

National Drug Company 323

Parke, Davis Company 372
Poythress, Wm. P. Company 337
Professional Service 377

Robins, A. H. Company 316
Roche Laboratories 327, 382

Sandoz 360
Searle, G. D. & Company 358, 359
Southern Optical Company 361

Wallace Pharmaceuticals 324-326
Warner-Chilcott 339-340
Winthrop Laboratories 381

as easy as NTZ®

An easy solution to the problem of nasal symptoms of hay fever, colds and sinusitis

easy to prescribe: just write NTZ Nasal Spray.

easy to recommend: just say NTZ Nasal Spray.

easy to use: just one spray in each nostril, quickly followed by a second spray. Repeat q. 3 h. or q. 4 h. for temporary relief.

easy to dispense: the outer sleeve of the package is removable for easy application of prescription label.

easy to remember: as easy as NTZ.

But more than a simple vasoconstrictor:

NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine®, 0.5 per cent, the more potent solution (adult strength) in a carefully balanced formula which includes:
Neo-Synephrine (brand of phenylephrine) HCl 0.5 per cent, decongestant
Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, antihistamine
Zephiran® (brand of benzalkonium, as chloride, refined) CI 1:5000, wetting agent

Available: NTZ Nasal Spray in squeeze bottles of 20 ml.; NTZ Solution in bottles of 1 oz. with dropper.



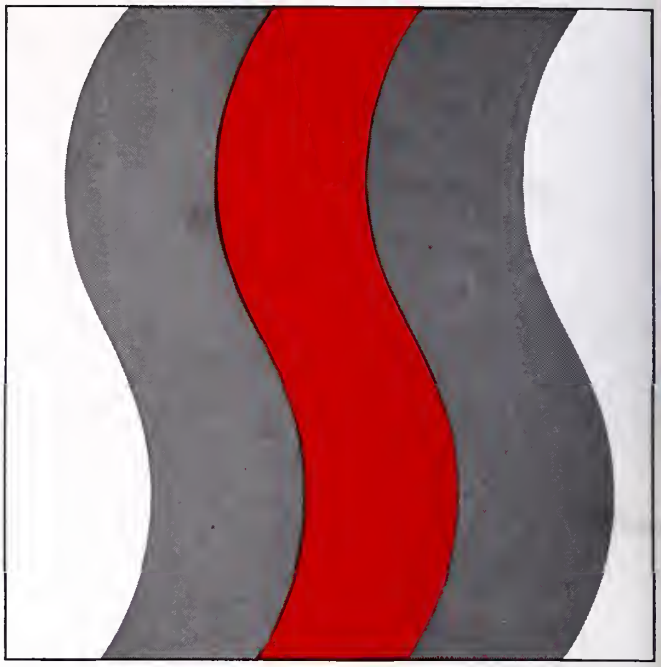
prescribe NTZ® Nasal Spray

(contains Neo-Synephrine)

Winthrop Laboratories, New York, N. Y. 10016 Winthrop



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, pleose consult complete product informotion, o summory of which follows:

Indications: Indicoted when onxiety, tension and apprehension ore significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

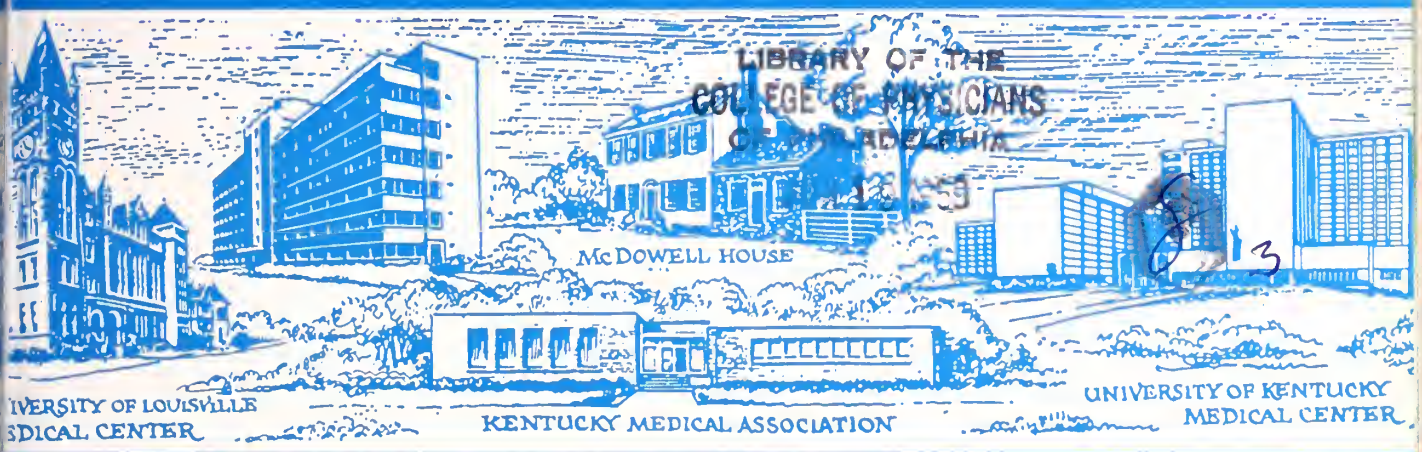
Warnings: Caution potients about possible combined effects with olcohol and other CNS depressonts. As with oll CNS-octing drugs, coution patients ogoinst hazordous occupotions requiring complete mentol olertness (e.g., operoting machinery, driving). Though physical and psychological dependence have rorely been reported on recommended doses, use coution in odministering to oddiction-prone individuals or those who might increose dosage; withdrowal symptoms (including convulsions), following discontinuotion of the drug and similor to those seen with borbiturates, have been reported. Use of ony drug in pregnoncy, loctation, or in women of childbearing oge requires thot its potentiol benefits be weighed ogoinst its possible hazords.

Precautions: In the elderly ond debilitated, ond in children over six, limit to smollest effective dosage (initiolly 10 mg or less per day) to preclude otoxio or oversedotion, increosing gradually os needed and tolerated. Not recommended in children under six. Though generolly not recommended, if combination theropy with other psychotropics seems indicated, carefully consider individuol phormocologic effects, particularly in use of potentioting drugs such os MAO inhibitors ond phenothiazines. Observe usuol precoutions in presence of impaired renal or hepotic function. Porodoxicol reoctions (e.g., excitement, stimulotion ond ocute roge) hove been reported in psychiotric potients and hyperoctive oggressive children. Employ usual precoutions in treotment of onxiety stotes with evidence of impending depression; suicidol tendencies moy be present ond protective meosures necessary. Voriable effects on blood coogulotion hove been reported very rorely in patients receiving the drug ond orol onticoagulants; causal relationship has not been estoblished clinicolly.

Adverse Reactions: Drowsiness, otoxia ond confusion moy occur, especiolly in the elderly ond debilitated. These are reversible in most instonces by proper dosage odjustment, but ore olso occosionolly observed ot the lower dosage ranges. In o few instonces syncope has been reported. Also encountered ore isoloted instonces of skin eruptions, edemo, minor menstruol irregularities, nouseo ond constipation, extropyromidol symptoms, increased ond decreosed libido—oll infrequent ond generolly controlled with dosoge reduction; chonges in EEG potterns (low-voltoge fost activity) moy oppeor during and after treatment; blood dyscrosios (including ogranulocytosis), joundice ond hepotic dysfunction hove been reported occosionolly, moking periodic blood counts ond liver function tests odvisoble during protrocted theropy.

VOLUME 67 JUNE 1969 NUMBER 6

The Journal of The KENTUCKY Medical Association



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

In This Issue

Chronic Disease Screening in a General Practice
Robert L. Kane, M.D. and J. Murray Walker, Jr. 409

Emergency Operation for Cyanotic Heart Disease in Infants
J. Kent Trinkle, M.D., F.A.C.S., Lester R. Bryant, M.D., F.A.C.S. and Jacqueline A Noonan, M.D. 413

A Study of Cholecystectomies in a Small Community Hospital
Romeo S. Berardi, M.D. 420

Special Article

Health Manpower—Mostly!
Donald E. Wood, M.D. 427

Complete Contents on page 386

KMA 1969 Annual Meeting—September 23-25
Convention Center, Louisville



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

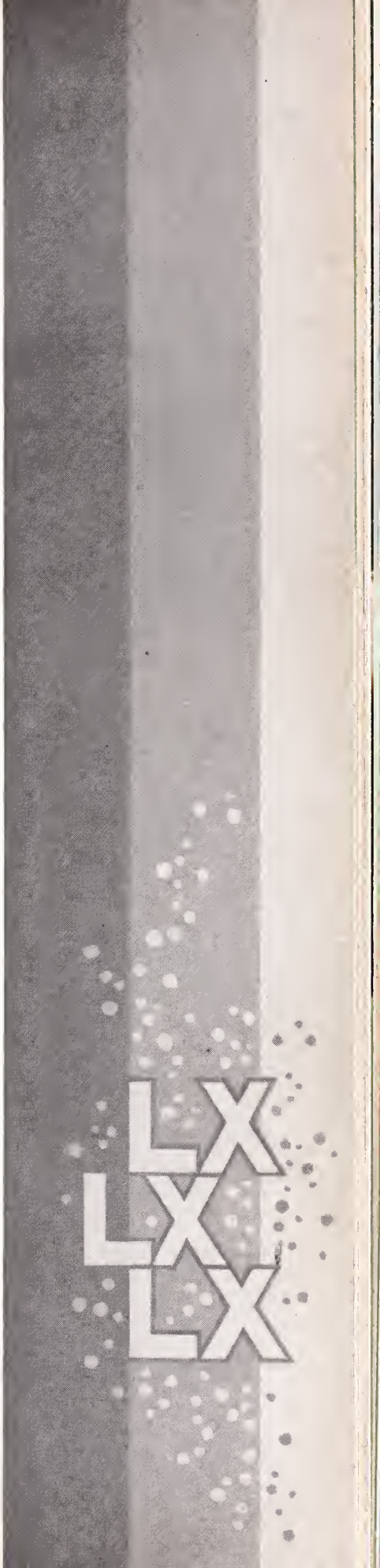
No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-DS)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Volume 67 • June 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Peggy Roberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussions
William W. Holl, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1971

McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Raddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970

Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Groy, M.D.
Peggy J. Howard, M.D.
Ray A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
John H. Willard, M.D.

Term Expires July 1, 1969

Paul E. Lett, M.D.
David A. Orrihood, M.D.
Harry A. Hamilton, Jr., M.D.
Leslie W. Blakey, M.D.
Raymond J. Timmerman, M.D.
William H. Gillespie, M.D.
J. J. Sanne, M.D.
John L. Creech, Jr., M.D

Published at 3532 Jonet Avenue,
Louisville, Ky. 40205
Phone (Area Code 5021 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Chronic Disease Screening in a General Practice
Robert L. Kane, M.D., and J. Murray Walker, Jr. 409

Emergency Operation for Cyanotic Heart Disease in Infants
J. Kent Trinkle, M.D., F.A.C.S., Lester R. Bryant, M.D., F.A.C.S. and Jacqueline A. Noonan, M.D. 413

A Study of Cholecystectomies in a Small Community Hospital
Romeo S. Berardi, M.D. 420

SPECIAL ARTICLES

Health Manpower—Mostly!
Donald E. Wood, M.D. 427

EDITORIALS

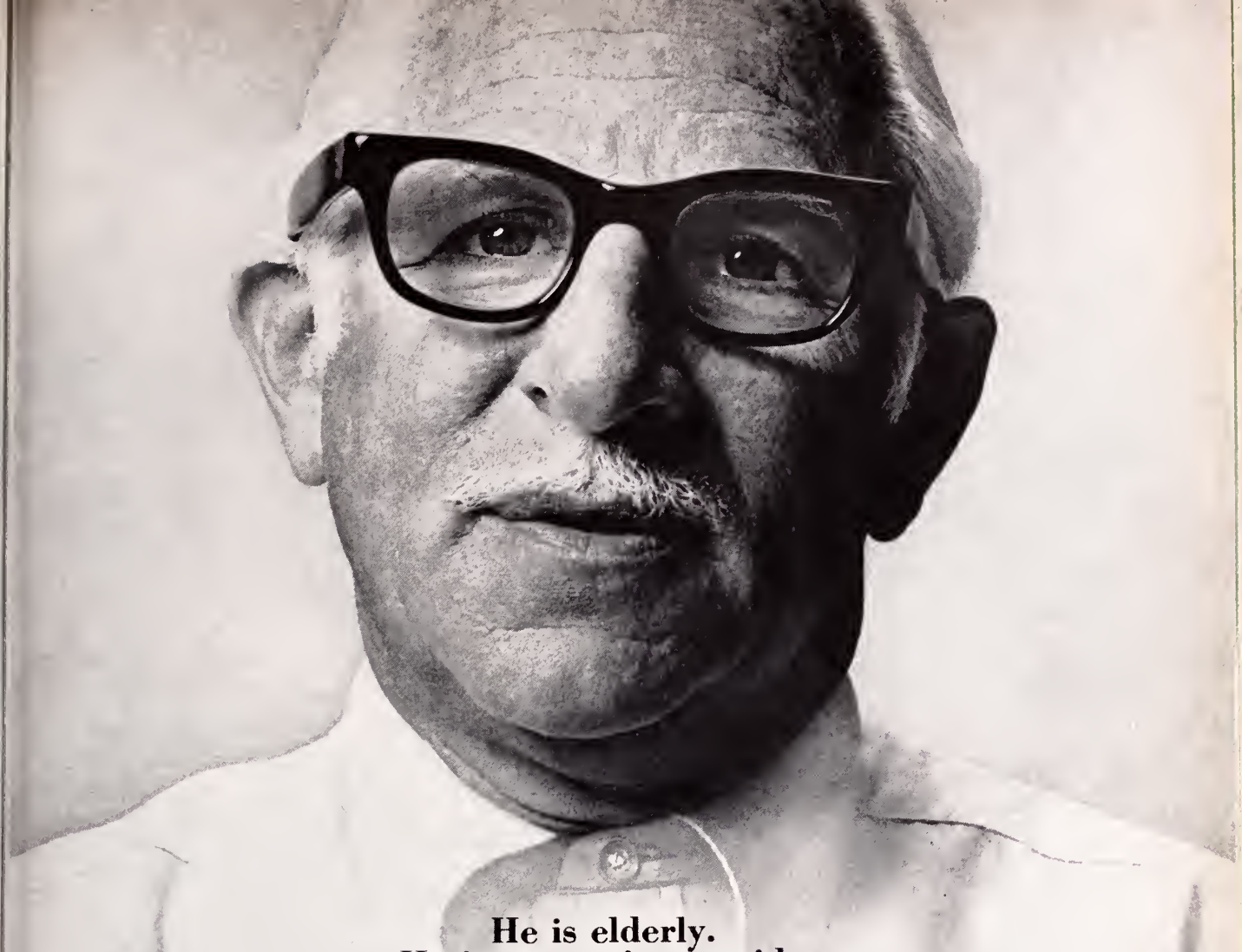
Ulcerative Disease of the Bowel
Sam A. Overstreet, M.D. 432

ORGANIZATION

New Crockerbarrel Session, Panel Discussions To Highlight Annual Meeting Sept. 23-25 442
St. Joseph Infirmary To Hold Cancer Symposium June 23 442
Journalist To Address Physicians at KMA President's Luncheon 443
KAGP Elects Dr. Roach, Honors Dr. Seeley 443
KMA Gives Auto Safety Award to Louisville VA Hospitol 443
Dr. Brockmon Takes Leave To Head TB Study Group 446
Mr. Frazier Named Pres.-Elect of Ky. Hospital Association 446
AMA House Adopts Resolution on Nursing Education 449

REGULAR FEATURES

President's Page 388
Insurance Page 390
Maternal Mortality Page 392
Postgraduate Opportunities 395
Medical Progress 401



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



More on Medicaid

AMIDST the continued nation-wide clamor over Medicaid costs and myriad other problems, your KMA officials have endeavored to work quietly and cooperatively with the Department of Economic Security and the KMAP administrators in an effort to alleviate some of the problems in Kentucky's program.

Sharing Commissioner Merritt Deitz' opinion, we believe that the most immediate solution to the financial difficulties of the program lies in the area of elimination of over-utilization and/or abuse, rather than in reduction of benefits or professional fees.

Last month, the Commissioner sent a group of specially trained social workers throughout the state, concentrating their efforts in the areas of greatest usage of the program, to interview recipients and physicians in an effort to determine the extent to which Medicaid is being over-utilized and if possible, the reasons why. In a personal communication, you were urged to cooperate with these investigators — and I believe that most KMA members did just that.

As of this writing, the results of those surveys have not become available. We believe that they will show that the vast majority of the physicians in Kentucky are working long hours, conscientiously endeavoring to deliver the best quality medical care that is possible. The fact that the program is exorbitantly expensive is the fault of the law — not of the physician who requests that he be reimbursed for his services in the manner in which the law provides.

It should not be necessary to reiterate, however, that KMA will not be placed in the position of defending any physician who has been found guilty of abuse of this program. Fraudulent actions are, of course, matters for the courts to consider; unethical behavior is of deep concern to KMA.

Henry B. Asman

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034



Here We Go Again

THE first concerted drive to promote national compulsory health insurance since the Truman administration is now taking shape. The formation a few months ago by Walter Reuther of a "Committee for National Health Insurance" with headquarters in Washington, D.C. was the first formal step. The purpose of the committee will be to mobilize "the broadest possible support to achieve the goal" of a national health insurance program for the United States. The committee is to comprise 100 "outstanding and concerned citizens" representative of medical and health groups, industry, farm and labor, education and social services, civil rights and consumer organizations. Three well-known citizens have thus far been designated vice presidents of the organization—Doctor Michael DeBakey of Baylor University, Whitney Young, Jr., executive director of the National Urban League, and Mrs. Mary Lasker, an active worker in previous nationalized medicine fights.

Mr. Reuther unveiled this new enterprise in a speech at the American Public Health Association's annual meeting in Detroit. Echoing one of the favorite themes of Senator Ribicoff's subcommittee hearings on health care problems, Mr. Reuther declared that we now have in America a "disorganized and disjointed, antiquated and obsolete nonsystem" of medical service, which the American people "are being required to subsidize." While conceding that "the insurance industry has made a constructive contribution," he declared that the "health care crisis" is beyond the industry's capability to cope with.

Bert Seidman, director of the AFL-CIO Social Security Department, spelled it out more bluntly in a speech before a St. Louis University graduate program in hospital administration. "If we want to have comprehensive health services in this country, and that is the real goal for which national health insurance is the most appropriate means, we can no longer afford to ignore the question of how physicians are paid . . . We would . . . want to institute some type of negotiation of physicians' fee schedules and hospital charges instead of present arrangements which largely permit providers to determine their own compensation." He concluded, ". . . if the unregulated fee-for-service, entrepreneurial system of delivering health care is to remain sacrosanct then we may as well resign ourselves to inefficient, costly, fragmented and ineffective health care of inferior quality."

This battle on nationalized medicine has waxed and waned since 1932. Organized medicine suffered a serious setback with the passage of the Medicare program under the Johnson administration. After a brief respite, it appears that the battle lines are again being drawn.

WILLIAM W. HALL, M.D.

DOCTOR... *you can recommend*

BLUE CROSS® and BLUE SHIELD®' health care prepayment plans with confidence because our subscribers receive

► **GREATEST DOLLAR USAGE** — More benefits per dues dollar are received through our prepayment system.

► **FLEXIBILITY** — Basic programs are designed to provide solid foundation for future needs.

► **REDUCE OVERHEAD** — Normally claims are submitted by the providers of care, and payment for covered services are paid direct to the providers.

► **COMPLIMENT TO COMMUNITY** — Benefits can be designed that fill individual as well as community health care needs.

► **CLIENT CONSULTATION** — Our representatives assure maximum results by keeping you and the public informed of changing health care patterns.

► **REALISTIC BENEFITS** — Our benefits help give financial peace of mind when sickness or accidents strike.

And Health Care Coverage Is Available For:

- **EMPLOYEE GROUPS**
- **ELIGIBLE INDIVIDUALS OR FAMILIES**
- **COLLEGE STUDENTS**
- **INDIVIDUALS 65 OR OVER**

If you are a physician practicing in Kentucky, age 64 or under, you and your employees are eligible for a Special Group Program. Persons 65 or older may apply for the Blue Cross and Blue Shield-65 Plan.

For more information, CONTACT our office nearest you.

BLUE CROSS® and BLUE SHIELD®'

BLUE CROSS HOSPITAL PLAN, INC. KENTUCKY PHYSICIANS MUTUAL, INC.

3101 Bardstown Road Louisville, Ky. 40205 (502) 452-1511

® Registered service marks of the American Hospital Association
®' Registered service marks of the National Association of Blue Shield Plans

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 12-67. A 22 year old married white prima-gravida whose expected date of delivery was May 1, 1967, began having regular uterine contractions at 9:00 a.m. on May 1, 1967. She was admitted to the hospital at 10:55 a.m., when examination showed her temperature to be normal, pulse 96, respirations 20, and blood pressure 138/84. The fetal heart beat was regular at 156 beats per minute, and were intact. On vaginal examination the cervix was closed and the presenting part was high. The patient was given an enema, and at 12:30 p.m. a Pitocin infusion was started consisting of two units of Pitocin in 500 cc of 5 percent glucose in water at 15-20 drops per minute.

The membranes ruptured spontaneously at 11:00 a.m. on May 2. Vaginal examination now showed the cervix to be one finger dilated with the presenting part low. Contractions were occuring every four minutes and lasting 45 seconds. She was premedicated with 100 mg of Demerol, 1/150 gr Scopolamine and 1 cc of Lorfan.

At 1:00 p.m. the contractions were occurring every three minutes lasting 45 seconds and the cervix was two fingers dilated. At 3:00 p.m. the cervix was three fingers dilated and the fetal heart rate was 140. The patient received 50 mg of Demerol, 1/300 gr Scopolamine and 1 cc Lorfan.

The patient was taken to the delivery room at 4:05 p.m. and given a saddle block consisting of 8 mg of Pontocaine with glucose for a volume of 2 cc. The Pitocin infusion was continued; her blood pressure was 150/70. At 4:15 p.m. her blood pressure was 100/60; at 4:20 it was 110/70; at 4:23 it was 80/50 and her lips were observed to be cyanotic. She was given Levophed, 1 cc in 1000 cc of 5 percent glucose in water. At 4:25 cardiac massage with resuscitation was given by her physician. Her pupils were dilated at 4:30 p.m. and no blood pressure could be obtained. An emergency postmortem Cesarean section was performed with delivery of a living 7 lb. 8 oz. male infant in critical condition at 4:45 p.m. The infant received Coramine and was resuscitated for 20 minutes, but he died at 1:57 a.m. The patient herself died within a few minutes after the administration of the saddle block anesthesia.

At autopsy the gross positive findings were pulmonary compression and atelectasis. Microscopic examination of the lungs showed only thickening of the interventricular septa. The pathologic diagnosis was lung compression atelectasis. The heart showed areas of considerable fragmentation of the myofibrils with some associated loss of cross striation. Alcian blue PAS stain tended to emphasize these changes and added strongly to the impression of myocardial damage. The diagnosis was myocardial degeneration. The spleen and the kidneys showed passive congestion, slight sub-acute and chronic glomerulonephritis. The pathologist thought this death was the result of acute myocardial failure due to myocardial degeneration. The relationship of the anesthetic agent to the death was considered speculative.

Comments

The Committee classified this as a direct obstetrical death with preventable factors on the part of the physician. This was considered an anesthetic death with the pathologist's comments questionable. The block was apparently administered too early for a primigravida, since the cervix was only 3 fingers dilated at 3:00 p.m. and the block was induced at 4:05 p.m. while the Pitocin drip was being continued. Had the cervix been completely dilated and had she developed hypertension, she could have been delivered much easier vaginally.



consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Warner-Chilcott Laboratories Division.

introducing

GELUSIL® M NEW

each 5 ml. teospoonful contains:
500 mg. magnesium trisilicote, 250 mg. aluminum hydroxide (Warner-Chilcott), 200 mg. magnesium hydroxide
U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

† Avoids constipation.

See next page for prescribing information ►

GELUSIL–one name to remember...and a dosage form for every patient



Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey

GM-IN-93-4C

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

IN KENTUCKY

JUNE

23 St. Joseph Infirmary Cancer Symposium, Lourdes Hall, Louisville

26 Sixth KMA Trustee District Meeting, Holiday Inn, Glasgow

JULY

16-17 KAGP Seminar, Jenny Wiley State Park, Prestonsburg

AUGUST

24 KAGP Bluegrass Seminar, Lexington

SEPTEMBER

23-25 KMA ANNUAL MEETING, Convention Center, Louisville

IN SURROUNDING STATES

JULY

12 Workshop on Diabetes Detection, Disease Detection Information Bureau, New York Hilton, New York, N.Y.

13 American College of Legal Medicine Annual Meeting, Warwick Hotel, New York, N.Y.

13-17 American Medical Association, 118th Annual Convention, New York, N.Y.

14-18 Simulation of Biological Systems Seminar, Los Angeles Analysis and Computation Center, Los Angeles, Calif.

AUGUST

10-15 American Congress of Rehabilitation Medicine Annual Session, Palmer House, Chicago, Ill.

17-22 American Congress for Physical Medicine and Rehabilitation, Chicago, Ill.

18-21 American Hospital Association Annual Meeting, Chicago, Ill.

SEPTEMBER

4-6 American Association of Obstetricians and Gynecologists, Hot Springs, Va.

15-16 Congress on Occupational Health, American Medical Association, St. Louis, Mo.

24-26 Cleveland Course in Pulmonary Diseases, St. Luke's Hospital, Cleveland, Ohio.

26-Oct. 3 American Academy of General Practice, Philadelphia, Pa.


NORGESIC
(orphenadrine citrate, 25 mg., aspirin, 225 mg.,
phenacetin, 160 mg., caffeine, 30 mg.)
non-narcotic analgesic

For musculo-skeletal pain,

try Norgesic first . . .

8 of 10 patients probably won't need anything stronger

NORGESIC offers predictable relief in approximately 80% of patients with painful musculoskeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. NORGESIC works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try NORGESIC first...eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, NORGESIC should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering NORGESIC to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.
Sponsors of Riker Service—
the complimentary classified service for physicians.

Medical Economics says:

GENERAL LEASING'S PLAN IS "The Winning Way" TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ **Leasing better than buying**
- ★ **No capital investment**
- ★ **Dependable car at all times**
- ★ **Certain tax advantages**
- ★ **Call us for particulars**

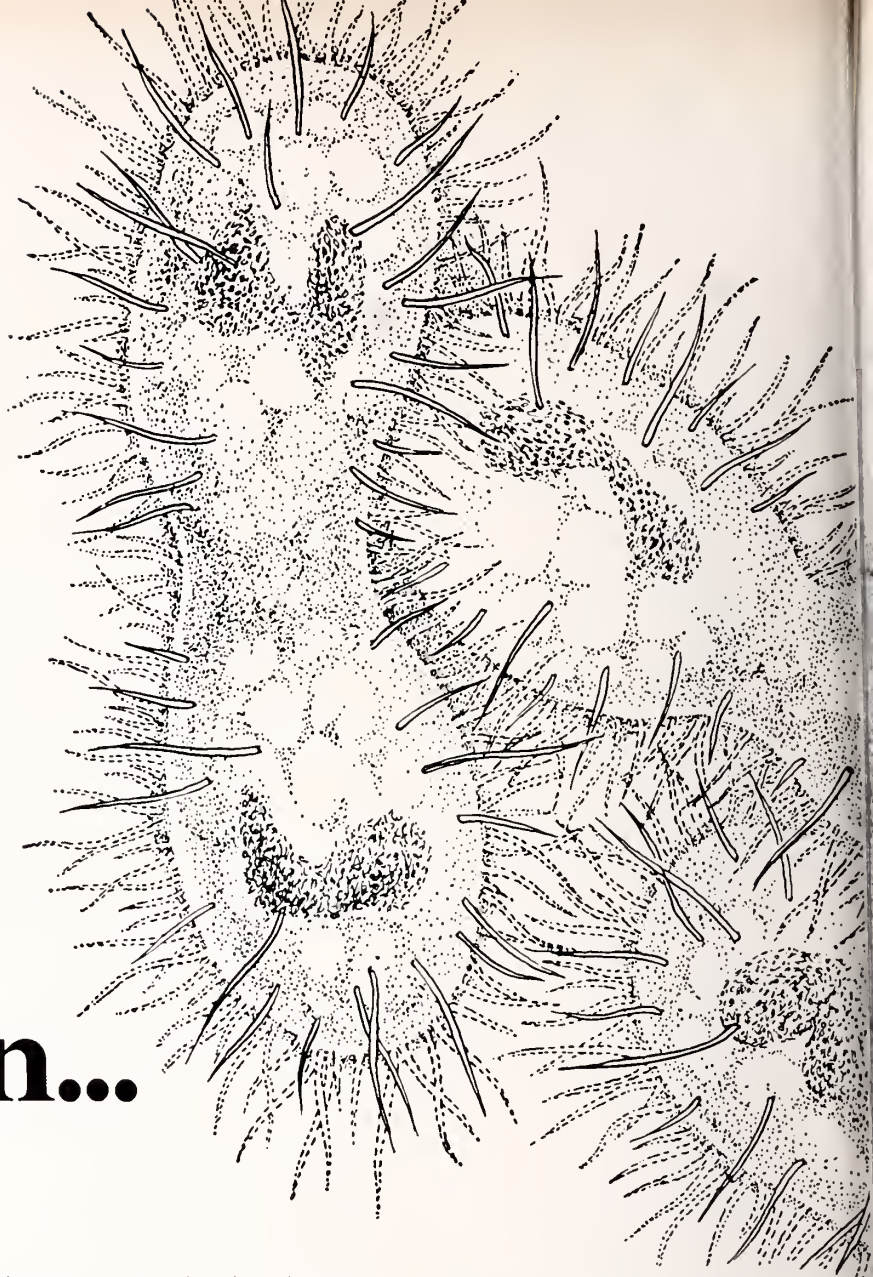
LEASE
Medical or Surgical
EQUIPMENT

- ★ **A plan for young doctors**
- ★ **Medical and Surgical equipment**
- ★ **Complete office furnishings**
- ★ **Enlarging facilities**
- ★ **Call us for full details**

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

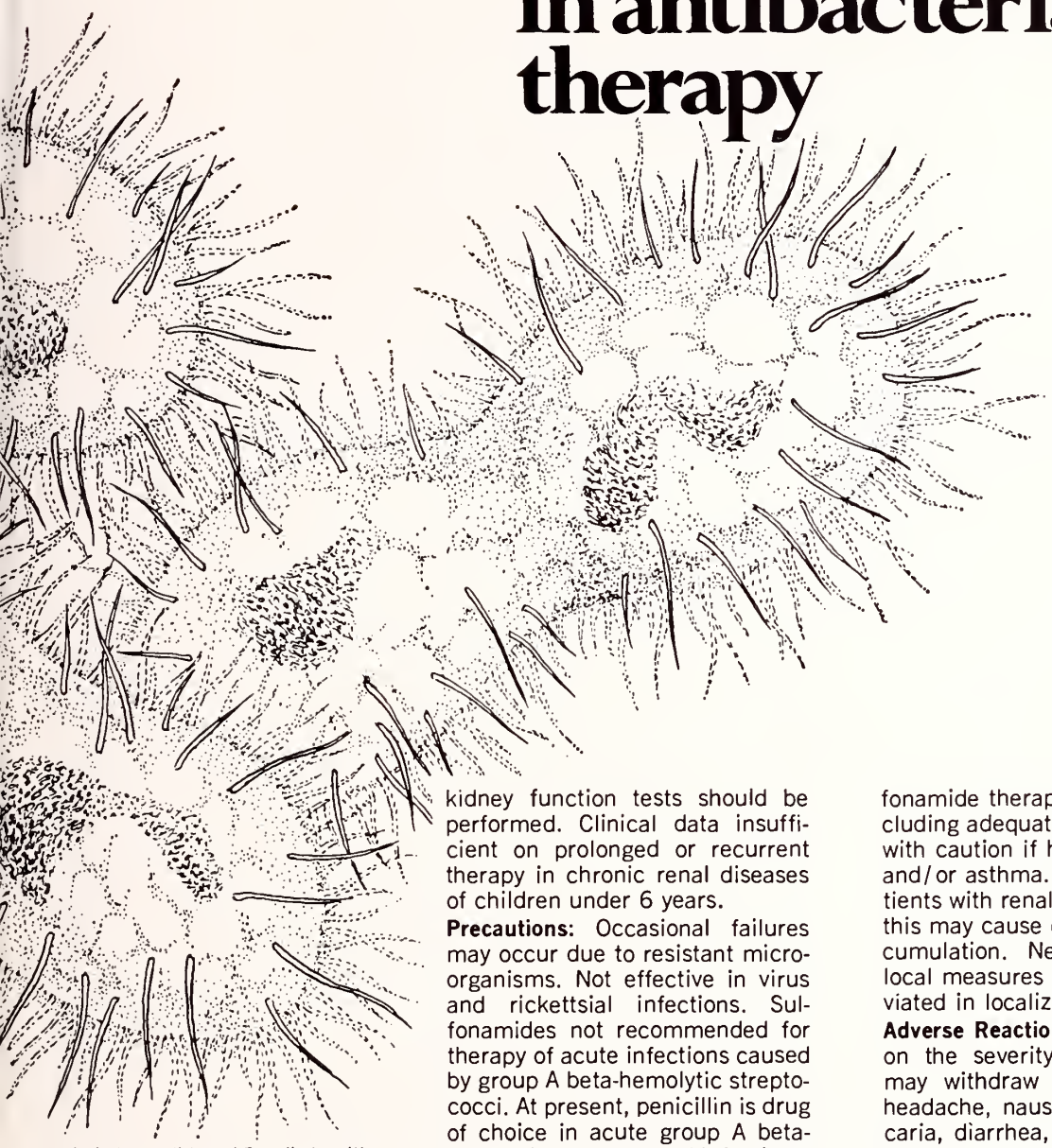
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days*. Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

—The lowest priced tetracycline—nystatin combination available—



50%

WHY PAY IT???

You don't have to with our new BUSINESS & PROFESSIONAL PRE-COLLECTION PLAN. All monies come direct to you.

GUARANTEED TO WORK

Write for full details, P.O. Box 172, Harlan, Kentucky 40831

WHAT'S NEW

in

Medical Progress

Pulmonary Embolism †

RICHARD P. O'NEILL, M.D. AND JAMES J. RAMS, M.D.

Thrombo-embolic disease and pulmonary embolism, its bedfellow, is a serious and frequent clinical problem. The frequency of diagnosis is directly related to the physician's familiarity with the problem. It is probably the most common pulmonary disease in the adult hospital population.[1] Discouragingly, the correct diagnosis is made in only some 25 percent of cases; in another 25 percent the diagnosis is suggested, but in about 50 percent, the diagnosis is completely missed.[2] The diagnosis and therapy of this disorder remains an enigma as the causative factors, the symptoms and the incidence are difficult to correlate with any degree of accuracy, mimicing many other acute chest disease processes. Factors associated with a high incidence of pulmonary embolism are stasis of the venous blood flow in the post-operative or cardiac patient, injury to the venous endothelium from trauma or infection, or an alteration in the coagulation-lysis factors of blood as in the female on oral contraceptives, the cancer patient, or in the patient with an idiopathic factor.

Pulmonary embolism may result from partial or complete occlusion of pulmonary vessels by blood clots, air, fat, cells or oil. The site of occlusion may involve a) the main trunk of the pulmonary artery, a catastrophic event which results in death in a few minutes; b) a main branch of the pulmonary artery which in a healthy, young individual may produce little measurable effect, or may produce pulmonary infarction. However, if the pulmonary circulation is compromised because of disease such as emphysema or fibrosis the result may be disastrous; c) embolic obstruction to lobar or lobular branches of the pulmonary artery which may be asymptomatic or may produce ventilation-perfusion abnormalities similar to but less in degree to those produced by main trunk occlusion. Continued emboli of this size may eventually produce pulmonary hypertension and cor pulmonale. Classically it is embolization to vessels of this size that results in infarction, with its own characteristic manifestations; and d) small vessels of arteriolar size giving rise to a condition known as miliary pulmonary embolism. This condition may be silent for many years, is often seen in young, child-bearing women, but it ultimately leads to gross dyspnea, marked tachypnea, pulmonary hypertension, cor pulmonale and death.

Pulmonary embolism is not synonymous with "pulmonary infarction", and is much more common. Embolism gives rise to an area of lung ventilated with air, but underperfused with blood. This results in an increased physiological dead space, abnormal ventilation-perfusion ratios, and arterial oxygen desaturation. Pulmonary infarction produces a non-ventilated, non-perfused area of lung. Pleuritic chest pain, pleural friction rib and consistent opaque radiological abnormalities are features of infarction and not of embolism. Confusion on these points is the main reason why pulmonary embolism is not more frequently diagnosed.

Pulmonary embolism is clinically complex because of its protean manifestations. Of its very nature, viz. in a vascular system, the situation is dynamic and not static. Miliary pulmonary embolism is frequently initially silent or produces evanescent symptoms which are considered psycho-somatic. Dyspnea and tachypnea are common but are often transient. Wheezing dypsnea of asthmatic type is seen and should be carefully evaluated in cardiacs and in the post-operative patient. Cough, sputum production and hemoptysis are frequent and probably result from congestion of the pulmonary circulation. The combination of tachycardia, unexplained fever, and angor animi, even if transient, should be viewed with suspicion. Chest pain, more often than not, is not pleuritic but is substernal, oppressive and may be similar to the pain of myocardial ischemia. Acute cor pulmonale is common and hypertension, anoxemia, convulsion and shock may result from left ventricular failure. Signs that are helpful are cyanosis, tenderness to light percussion over the thorax, prominent pulsation along the right sternal border together with a loud pulmonic second sound, a pulmonic systolic murmur and a diastolic gallop

†*From the departments of medicine and surgery, University of Kentucky College of Medicine, Lexington*

rhythm. Occasionally crepitations and wheezing can be elicited, particularly in the post-operative patient.

There is rarely appreciable leucocytosis or serum enzyme elevation in pulmonary embolism as contrasted with infarction. Frequent electrocardiographic tracings are essential if this procedure is to be useful. The frequency with which EKG will reveal changes is disputed, Wolff[3] stating that transient changes are seen in 75 percent of patients with significant embolism whilst Miller[4] reported changes in only 15-30 percent. The patterns which may appear are: S_1 - Q_3; development of S_1, S_2, S_3; ST segment depression in leads I and II; appearance of right axis deviation and change to vertical heart position; flat or inverted T waves in leads II and III; peaked P waves in leads II, III, and AVF; development of marked clockwise rotation of the heart; appearance of right heart block or right ventricular enlargement patterns; and inverted T waves with ST segment deviations in the right precordial leads.[5]

Arterial blood gas studies are helpful in a previously healthy patient without cardio-pulmonary disease and show a decreased PaO_2 and $PaCO_2$. The chest x-ray, at first glance, is strikingly normal other than for the rare phenomenon in embolism of pulmonary edema. Occasionally, either unilateral or bilateral pleural effusions can be seen without evidence of associated pulmonary infarction. The radiograph should be carefully scrutinized for localized increased radiolucency with associated oligemia; oligemia accompanied by pleonemia of the unobstructed lung; change in size and shape of the heart, indicating right ventricular dilatation; dilated hilar arteries above 1.2 cm; dilated pulmonary artery trunk; and dilatation of the azygos vein and the superior vena cava. A portable chest x-ray is not satisfactory for these observations.

Much has been written on the usefulness of pulmonary radioisotope scanning (Wagner, Taplin). However the scan does not detect emboli as such; rather it shows the distribution of pulmonary arterial blood flow and this latter is altered in a great variety of cardio-pulmonary conditions where embolism is most commonly met. [6,7]

Pulmonary angiography is the most useful laboratory study available to make a definitive diagnosis of pulmonary embolism. It can pinpoint the site of a major embolus and therefore is of great value, especially where pulmonary arteriotomy is under consideration. It is doubtful however, if it is useful in localizing a small peripheral embolism. Further, it requires special training and complicated equipment.

The key to therapy of pulmonary embolism is prevention. General measures, in use before the advent of anticoagulants, should be instituted; 1) elevation of the legs, 2) avoidance of pressure points to venous return, 3) foot and leg exercises, and 4) supportive stockings. The current standard treatment is anticoagulant therapy. This helps to inhibit clot formation in the focal area and prevent extension of the embolus. Therapy is begun with heparin, accompanied by coumadin (Warfarin Sodium). After 48 hours the heparin can usually be discontinued. The dosage of coumadin is regulated by the prothrombin time which is maintained at 20-30 percent normal. The exact usefulness of new fibrinolytic drugs, such as streptokinase and urokinase, has not yet been established. Oxygen therapy is important in preventing serious anoxemia, and it is an excellent pulmonary vaso-dilator. Should gross hypoventilation ensue on embolism, assisted ventilation is mandatory. Embolectomy is only used in selected cases of massive embolism. The mortality of the procedure is high but this has to be weighed against the fact that the patient may have little or no chance of survival without surgery. Surgery is also used where good medical measures have failed to prevent recurrent embolization. Either ligation or plication of the inferior vena cava or its tributories can be carried out. The former is associated with varying degrees of disabling venous stasis of the lower extremities and unfortunately, following either procedure, continued embolization may occur. Lastly people with a history of either thrombophletitis and/or pulmonary embolism should avoid coagulant drugs, notably the "pill'.

References

1. Israil, H. and Goldstein, F. "The Varied Clinical Manifestations of Pulmonary Embolism", *Ann. Int. Med.* 47: 202, 1957.

2. Freiman, D.G., Suyemoto, J. and Wessler, S. "Frequency of Pulmonary Thromboembolism in Man", *N.E.J. of Med.* 272: 1278, 1965.

3. Wolff, L. "Pulmonary Embolism", *Cir.* 6: 768: 1952.

4. Miller, R. and Berry, J.B. "Pulmonary Infarction: A Frequently Missed Diagnosis", *Am. J.M.Sc.* 222: 197, 1951.

5. Parker, B.M. and Smith, J.R. "Pulmonary Embolism and Infarction", *Am. J. Med.* 24: 402, 1958.

6. Wagner, H.N., Sabestin, D.C., McAfee, J.G., Tow, D. and Stein, H.S. "Diagnosis of Massive Pulmonary Embolism in Man by Radioisotope Scanning", *N.E.J. of Med.* 271: 379, 1964.

7. Bryant, L.R., Cohn, J.E., O'Neill, R.P. and Greenlaw, R.H. "Distribution of Pulmonary Blood Flow in Chronic Airway Obstruction", *Am. Rev. Resp. Dis.* 97: 832, 1968.

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

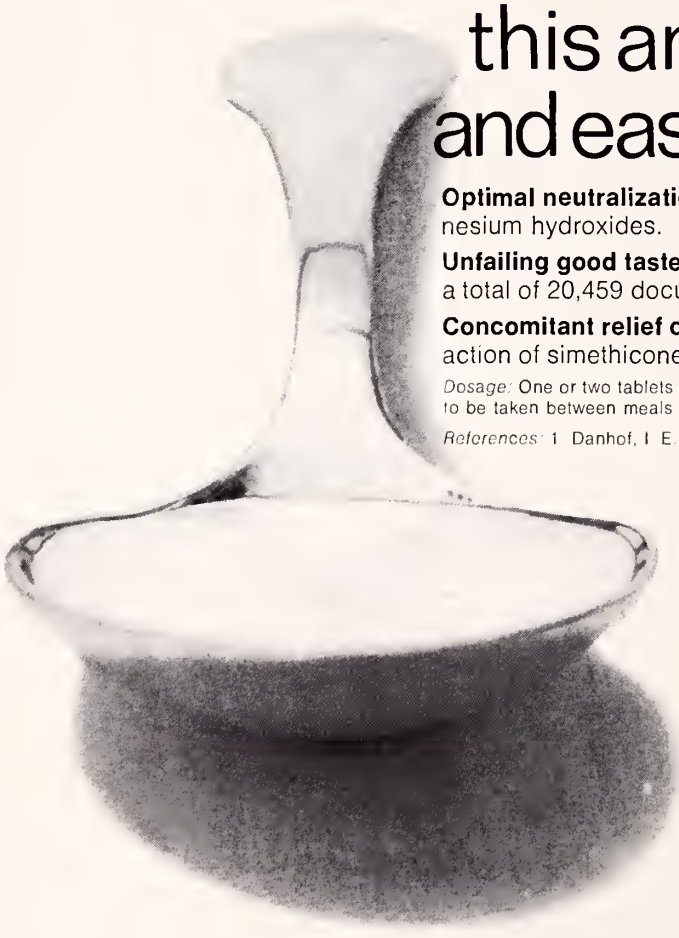
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E. Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®

LIQUID/TABLETS

aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8


P
M
P
M

The go-ahead-and-enjoy-your-vacation summer cold and allergy pill.

Novahistine LP lets you provide effective relief of summer cold and allergy symptoms, lets your patients go ahead and enjoy their vacations.
These continuous-release, decongestant tablets contain a vasoconstrictor-antihistamine formulation that goes to work promptly and lasts for hours. Even the nasal congestion resulting from repeated allergic episodes can usually be relieved by Novahistine LP.

And, convenient twice-a-day dosage lets most patients enjoy relief all day and all night. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

DOW

Novahistine®
LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)


Lilly
H06
Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 JUNE, 1969 No. 6

Chronic Disease Screening in a General Practice†

ROBERT L. KANE, M.D.* AND J. MURRAY WALKER, JR.**
Lexington, Kentucky

Using the experience of a screening study in a general practice population, this paper examines some of the difficulties and limitations of screening procedures.

SCREENING for various chronic diseases has stimulated growing interest in medical practice. With the recent development of automated laboratory equipment, it is now possible to obtain biochemical data rapidly, accurately and economically on large numbers of individuals. Bryan et al. studied hospitalized patients and claimed to have discovered many significant conditions which might otherwise have gone undiagnosed.[1] Screening centers using a variety of screening techniques including computerized histories and multi-channel autoanalyzers have extolled the value of early disease detection.[2] Others have used screening procedures to gather epidemiologic information on populations to seek risk factors that might identify susceptible individuals before the disease is manifest.[3,4]

Scott and Robertson used a British general practitioner's caseload as a base population for screening.[5] They invited all females registered with the practice to participate in a series of screening tests. Such a practice is not feasible under the American system since patients do not belong to the physician in the same way, nor do our current medical ethics sanction such invitations. The present study was designed to examine several examples of screening tests which might be carried out on patients who have come to their physicians for other reasons.

Methods

This study was carried out on the adult office patients of a general practitioner in a small rural town in Kentucky. All patients over age 35 seen by the local physician in his examining rooms Monday through Friday over a three week period in the fall of 1968 were included in the study population. One hundred fourteen persons were eligible to participate in the study. Six refused; two were omitted because they were felt to be in too acute distress. Three inadvertently escaped inclusion. Of the 103 persons included, the median age was 59 years. Forty persons were male and 63 female; all were white. Each person who agreed to participate was interviewed in an examining room, usually while waiting to see the doctor, by one of the authors. A brief interview schedule about eye symptoms and known illness was completed and a specimen of blood was obtained. Ocular tension was then measured by a Schiotz tonometer.

†*From the department of community medicine, University of Kentucky Medical Center, Lexington*
**Resident, department of community medicine, University of Kentucky Medical Center*
***Senior medical student, University of Kentucky College of Medicine*

Any patients with readings between 21mm and 23mm mercury were re-checked on two other days. Any persons with readings persistently greater than 21mm mercury were referred to an ophthalmologist.

The blood samples were forwarded to the Kentucky State Department of Health for analysis of cholesterol, urea, and uric acid. The normal values used were those of the state laboratory (urea 10-25mg%, uric acid 2-6mg%, cholesterol 150-250mg%). The medical histories were supplemented by reference to the physician's files; the results of the screening procedures were then compared with the medical information previously available to the local practitioner.

Results

Of the 43 persons with an elevated serum cholesterol, nine (21%) had a history of coronary heart disease and 11 (26%) had a history of hypertension. One person had both coronary heart disease and hypertension; one had a resected abdominal aneurysm. The remaining 21 (49%) with elevated cholesterol were asymptomatic. The abnormal values ranged from 255 to 400 with a mean of 289 and a median of 277.

Four persons had an elevated blood urea nitrogen (BUN 26, 28, 28, 38). Although none was diagnosed as having renal disease, three persons had hypertensive cardiovascular disease and the fourth had arteriosclerotic heart disease with congestive heart failure.

Fifteen people had an elevated uric acid. None of the persons studied had clinical gout; however, four patients had arthritis. Seven patients (including one with arthritis) were taking oral sulfonamide diuretics which may have accounted for the hyperuricemia.[6] The abnormal uric acid values ranged from 6.2 to 9.5 with a mean of 7.4 and a median of 7.2. Data from the Framingham studies suggest that only one person in 10 with a serum uric acid level of six or greater will develop gouty arthritis.[7] Furthermore, uric acid levels in the same individual are subject to fluctuation.[8] Seven persons had elevations of more than one chemical value. No one had elevations of all three.

Tonometry represents another modality of screening, simple quick tests which can be performed on the spot by trained assistants. Ninety-four persons had intraocular pressures (IOP) less than 21.0 mm mercury. One patient with an abnormal pressure was being followed for glaucoma. Of the eight persons referred to ophthalmologists with an intra-ocular pressure greater than 21.0 mm mercury, two were diagnosed as chronic open angle glaucoma and are on medication, two were thought to have possible open angle glaucoma and are being followed by an ophthalmologist; two were false positives; and follow-up information is not available on the remaining two, who apparently had not seen the ophthalmologist to whom they had been referred.

The questions on blurred vision were of no assistance in distinguishing those with elevated intra-ocular pressures. The patients seen in this study were receiving a wide variety of drugs which may have had various effects on these serum determinations and intra-ocular pressure measurements.

Discussion

It might seem the results of these two types of screening tests may have different implications. The patient with increased intra-ocular pressure represents a clinical problem needing appropriate treatment, as does the patient with inadequate refraction, impaired hearing or a positive Pap smear. For the patient with an elevated cholesterol, no diagnosis is immediately forthcoming, only a suggestion, with varying degrees of certainty, of an increased risk of developing one or more diseases. However, the thin line between action and inaction cannot be drawn so clearly. Is an intra-ocular pressure of 21.1 really different from a cholesterol of 260, or a two-hour post prandrial blood sugar of 125 or a "suspicious" Pap smear? While the confidence limits of probability may be readily utilized in epidemiologic surveys on population groups, they are less comfortably applied to individual patients. The imposition by laboratory fiat of a disease on an otherwise healthy individual places a heavy burden on both physician and patient. (*Primum non nocere*). Recourse to repetition of the "abnormal" value implies a hope that the second result will be more strongly positive or negative. In the event of a discrepancy, there is no obvious explanation

why this second result should have more validity than the first; or, conversely, all normal results should require the same confirmation.

The value of a screening test is generally agreed to rest on three basic points. 1) It should be sensitive (produce true positives). 2) It should have a high specificity (produce true negatives). 3) It should be economical (in terms of both time and money). To these a fourth important criterion must be added: 4) A positive (or confirmed positive) finding should lead to some meaningful action whereby the health of the patient is improved.

Chronic disease screening has been assailed by its detractors on all four of these points. There is a problem of establishing confidence limits for test values which are simultaneously sensitive enough to detect disease and specific enough to prevent undue alarm over disease which is not truly present. There are few things so distressing as an abnormal laboratory result for which no disease can be found. Furthermore, the "normal range" appears to vary for different age groups and sexes.[9] Rarely is there agreement on the appropriate level for referral, as for example, in the glaucoma. Hollows and Graham have shown that for every 1000 persons over age 40 tested, 90 will have an intra-ocular pressure more than two standard deviations above the mean; only 4-5 of these will have ophthalmologic evidence or chronic simple glaucoma.[10] Thus, 20 patients must be referred (at this level) to find one true case. More specialists are required before such a program is feasible on a large scale basis. Large glaucoma screening projects in Philadelphia and Cleveland had referral/new case ratios of 8.1 and 5.4 respectively.[11]

Economies of scale have sometimes prompted the application of screening tests onto inappropriate populations. Once an institution has invested in the necessary equipment, each person utilizing the resource reduces the unit cost. Screening is no longer restricted to high risk groups where the expectation of a positive yield is greater.

What happens as a result of the screening? Most of today's major illnesses are chronic conditions. The crude ecologic information available suggests that behavioral factors may have an important etiologic role. To be useful in altering the course of disease, screening should thus lead to some change in behavior, but is screening necessary to initiate such interactions? We now "know" that smoking has a detrimental effect on several serious conditions. We already appreciate the dangers of obesity in cardiac disease and diabetes. Screening tests are not necessary to direct the heavy smoker or the obese patients. However, such tests may be useful to convince the patient of the need for behavioral changes, changes which he might otherwise choose to forego. Essential, therefore, to any screening test is the provision of adequate follow-up.

This need for follow-up, as well for understanding the epidemiology of the disease, may have great bearing in determining the target population for screening. Clearly those persons who have the least ability to cope with the medical care system (generally the indigent) will most likely not be motivated to initiate action against asymptomatic disease. Thus a dilemma emerges; persons potentially in the high-risk group may also be the least motivated to act on the information generated. Programs developed for a health-oriented clientele (like the Kaiser Foundation Medical Program[2]) cannot be transferred directly to low income populations; nor is any evidence available yet to demonstrate their effectiveness in improving health levels among the more affluent. Wilson and Jungner are particularly critical of mass multiphasic screening operations, which they term a "blunderbuss technique that too often gives a low yield for a high expenditure of resources" by failing to concentrate on high risk groups and on conditions for which a specific therapy is available.[12]

Is there a rationale for screening? Critics are often quick to point out that even in the case of a readily treatable condition like carcinoma of the cervix, screening programs have not produced any discernible change in mortality.[13] Schor et al. found little correlation between conditions discovered by screening and those determined after death.[14] Hutchison's analysis of the preventive orientation stresses the crucial importance of timing;[15] the screening procedure must detect disease while treatment will still alter the natural

course of the disease. Others are content with only the lessening of symptoms or improvement in the quality of life. In England, there is a growing lessening of enthusiasm for major screening projects until some of these problems can be evaluated.[16,17]

Is there a role in screening for the individual practitioner? The results of this small study would appear to suggest that new information may be gained from some screening tests. The value of this information must be evaluated by the practitioner himself. Added to the patient's medical record, it may result in the serendipitous discovery of an unsuspected condition. Used as a piece of data by which the patient may be convinced to alter his behavior, the screening test may become a potent tool.

The physician may elect to do his own screening, in which case he will probably have to limit his activities to a few procedures; the choice of these procedures should be based on the ability to detect true disease readily and to provide an appropriate therapy. He may be able to utilize one of the several screening centers being established by both public and private medicine; however, the same criteria for screening's effectiveness should apply. The doctor who undertakes a regular screening program must be prepared to see the proportion of normal findings increase with time. After the initial screening, repeat checks will have a much lower yield. No longer is one detecting the prevalence of a sign, only its incidence.

Summary

A series of adult patients from a rural Kentucky general practice were screened for blood urea, cholesterol, and uric acid and for intraocular pressure. None of the 103 patients had abnormal tonometry; two of these represented new cases brought under treatment. Of the 43 persons with abnormal cholesterol, only 49% were truly asymptomatic. All four persons with elevated BUN had a history of some related condition which could suggest this finding. Of the 15 patients with elevated uric acid, four had some type of arthritis and seven were on diuretics. The value of screening in general practice is discussed.

Acknowledgment

We should like to acknowledge the cooperation of Calixo Hernandez, M.D., director of the division of epidemiology, State Health Department, in analyzing the serum specimens.

References

1. Bryan, D. J., Wearne, J. L., Viau, A., Musser, A. W., Schoomaker, F. W., and Thiers, R. E. Profile of Admission Chemical Data by Multichannel Automation: An Evaluative Experiment. *Clinical Chemistry, 12:*137-143, 1966.

2. Keene, C. H. The Social Organization of Medicine. *Harvard Public Health Alumni Bull., 22:*3-12, (suppl.), August, 1965.

3. Dawber, T. R., Meadors, G. F., and Moore, F. Epidemologic Approaches to Heart Disease: The Framingham study. *Am. J. Pub. Hlth., 41:*279-86, March, 1951.

4. Epstein, F. H. An Epidemiologic Study in a Total Community: The Tecumseh Project. *Univ. Mich. Med. Bull., 26:*307-14, 1960.

5. Scott, R. and Robertson, P. D. Multiple Screening in General Practice. *Brit. Med. J., 2:*643-647, June, 1968.

6. Brest, A. N., Heider, C., Mehbod, H., and Onesti, G. Drug Control of Diuretic-Induced Hyperuricemia. *JAMA, 195:*42-4, January, 1966.

7. Hall, A. P., Barry, P. E., Dawber, T. R., and McNamara, P. M. Epidemiology of Gout and Hyperuricemia. *Am. J. Med., 42:*27-37, Jan., 1967.

8. Bauer, W. The Diagnosis of Gout. *New Eng. J. Med., 229:*583, 1943.

9. Files, J. B., Van Peenen, H. J., and Lingberg, A. B. Use of "Normal Range" in Multiphasic Testing. *JAMA, 205:* 684-688, Sept., 1968.

10. Hollows, F. C., and Graham, P. A. A Critical Review of Methods of Detecting Glaucoma. In *Glaucoma, Epidemiology, Early Diagnosis, and Some Aspects of Treatment.* Proceedings of a symposium held at the Royal College of Surgeons of England (Edinburgh, Livingstone, 1966).

11. Screening for Glaucoma. U.S. Department of Health, Education, and Welfare, *Public Health Service Publication No.* 666 (Washington, 1959).

12. Wilson, J.M.G. and Jungner, G. Principles and Practice of Screening for Disease. *WHO Chronicle, 22:*473-83, November, 1968.

13. Cochcrane, A. L. *Screening: The Case Against It.* Paper presented at the meeting of the Association of Teachers of Preventive Medicine, November, 1968.

14. Schor, S. S., Clark, T. W., Parkhurst, L. W., Baker, J. P. and Elsom, K. A. An Evaluation of the Periodic Health Examination: The Findings of 350 Examinees Who Died. *Ann. Int. Med., 61:*999-1005, December, 1964.

15. Hutchison, G. B. Evaluation of Preventive Services. *J. Chron. Dis., 11:*497-508, May, 1960.

16 Who's for Screening? (Leading article). *Lancet, ii:* 706-07, September, 1967.

17. Doubts About Screening. *Nature, 220:*527-28, November, 1968.

Emergency Operation for Cyanotic Heart Disease in Infants†

J. Kent Trinkle, M.D., F.A.C.S.,* Lester R. Bryant, M.D., F.A.C.S.** and Jacqueline A. Noonan, M.D.***

Lexington, Kentucky

Most infants with cyanotic heart disease can be saved if a precise diagnosis is made by cardiac catheterization and followed by immediate operation. Delay is the greatest enemy of the physician—and the infant!

CYANOTIC heart disease in the newborn or young infant is not hopeless! With modern diagnostic and surgical techniques many "blue babies" can have a long and normal life. Some can only be offered palliation in the hope that a totally corrective operation will soon be developed. To a very few we can offer nothing at present. However, the few infants with uncorrectable lesions should not be allowed to cast an air of pessimism on the many babies that can be saved.

Not all cyanotic infants have congenital heart disease. Cyanosis can be produced by such things as hyaline membrane disease, aspiration pneumonitis, lung cysts and diaphragmatic hernia. However, unless some noncardiac etiology of the cyanosis is obvious, cardiac catheterization is frequently necessary to rule out a correctable cardiac anomaly. The physician must not procrastinate since time, hypothermia, acidosis and hypoxia are working against the infant. Oxygen, digitalis, sodium bicarbonate and a warm isolette may provide temporary relief; but, these measures are no substitute for prompt cardiac catheterization and operation.

This article presents a discussion of the seven most frequent types of cyanotic congenital heart disease, and the current surgical management of each lesion.

Tetralogy of Fallot

(Fig. 1A) This is a combination of four lesions: Pulmonic stenosis, ventricular septal defect, right ventricular hypertrophy and overriding of the aorta. Due to the pulmonic stenosis, most of the venous blood in the right ventricle passes via the VSD into the overriding aorta producing cyanosis. The severity of the anomaly depends on the degree of pulmonic stenosis—with mild stenosis there is normal pulmonary blood flow and the patient may survive to adulthood. With severe stenosis very little blood reaches the lungs and the patient may die in the first few weeks of life. Infants with the severe form of Tetralogy may be pink at birth, while the ductus arteriosus is still patent, but become cyanotic in a few days. They tend to have syncopal episodes with crying when pulmonary blood flow is reduced. There is usually a systolic murmur along the left sternal border. The chest x-ray reveals a "boot-shaped" heart and clear lung fields due to the reduced pulmonary blood flow. EKG indicates right ventricular hypertrophy.

Complete correction can be accomplished by suturing a prosthetic patch over the VSD and excising the pulmonic stenosis. This operation is done with cardiopulmonary bypass but the mortality rate is extremely high if performed before four or five years of age. Infants and younger children with life-threatening, severe cyanosis need palliation by increasing

†*From the departments of surgery and pediatrics, University of Kentucky Medical Center, Lexington*
**Assistant professor, division of cardiothoracic surgery*
***Associate professor, division of cardiothoracic surgery*
****Associate professor, division of pediatric cardiology*

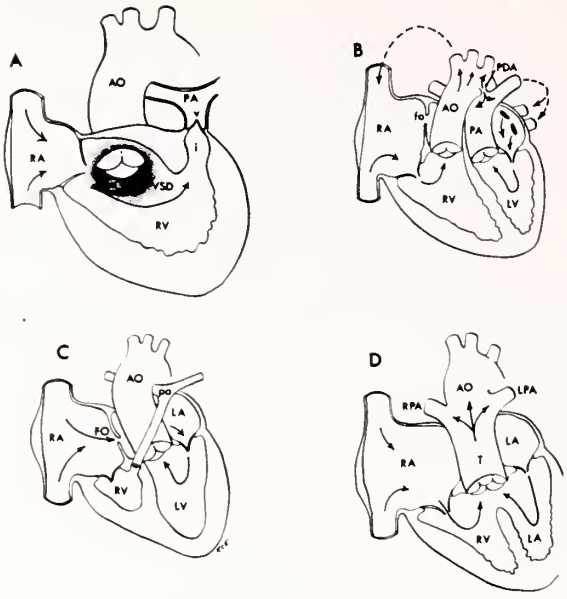


FIGURE 1. A. Tetralogy of Fallot. Stenosis is present of the pulmonic valve (v) and the infundibulum (i). Blood flow into the pulmonary artery (PA) is reduced and unoxygenated blood passes through the ventricular septal defect (VSD) and out the aorta (AO) which over-rides the VSD. The right ventricle (RV) is hypertrophied.

B. Transposition of the Great Vessels. The origin of the aorta (AO) and the pulmonay artery (PA) are reversed. The aorta arises from the right ventricle (RV) and the pulmonary artery from the left ventricle. Systemic venous blood returning to the right side of the heart is pumped back into the aorta, and pulmonary venous blood is returned to the pulmonary artery and lungs. The only mixing between these independent circuits is via the patent foramen ovale (FO) and patent ductus arteriosus (PDA).

C. Tricuspid and Pulmonic Atresia. Little or no blood passes through the tricuspid valve into the underdeveloped right ventricle (RV) and pulmonary artery (PA). Systemic venous blood passes through the patent foramen ovale to the left atrium where it mixes with the pulmonary venous blood.

D. Truncus Arteriosus. Both ventricles pump blood into a single large vessel (T) which in turn gives rise to the aorta (AO) and pulmonary arteries (RPA & LPA).

the pulmonary blood flow. This can be accomplished by anastomosing the subclavian artery to either pulmonary artery (Fig. 4),[1] or by creating a fistula between the ascending aorta and the proximal right pulmonary artery (Fig. 5)[2]. The subclavian-pulmonary artery shunt is generally used only in larger infants, over 12 months and 20 lbs., where the subclavian artery is large and can be readily anastomosed. The aorta-right pulmonary artery shunt is used in smaller infants. Both types of shunts are closed when total correction is performed at five or six years of age.

Transposition of the Great Vessels

(Fig. 1B). In this lesion the great vessels are reversed so that the aorta arises from the right ventricle and the pulmonary artery from the left ventricle. Venous blood returning to the right side of the heart is pumped into the aorta without being oxygenated; and, oxygenated blood returning via the pulmonary veins to the left side of the heart is pumped into the pulmonary artery and back to the lungs. These two completely independent circulations, one systemic and one pulmonary, would be incompatible with life except for some mixing through a patent ductus arteriosus and a patent foramen ovale.[3] Infants with "transposition" are usually large and robust but intensely cyanotic. There is no murmur unless a VSD or pulmonic stenosis is also present. EKG demonstrates right ventricular hypertrophy. Chest x-ray reveals increased vascular markings due to venous congestion. The heart is egg-shaped with a narrow superior mediastinum since the aorta lies anterior to the pulmonary artery rather than side-by-side.

Total correction of transposition of the great vessels can be performed by shunting systemic venous blood into the left atrium and the pulmonary venous blood into the right atrium, thus transposing the venous return to the heart to fit the transposed great vessels[4]. This operation requires cardiopulmonary bypass and carries a prohibitive mortality rate in infants. Therefore, a palliative procedure must be carried out to increase mixing between the two blood circuits to allow the infant to survive until three or four years of age when complete correction can be performed. The procedure most widely used is the Blalock-Hanlon shunt[5] which creates a large atrial septal defect. (Fig. 6) It is usually necessary to perform this operation within the first few weeks of life before the ductus arteriosus and foramen ovale close. Recently a balloon septostomy, a non-operative palliative procedure has been used.[6] During cardiac catheterization, a catheter with a small balloon on the tip is passed through the foramen, thus enlarging it and creating an atrial septal defect. This procedure is safe and does not require a thoracotomy; however, the infants frequently outgrow

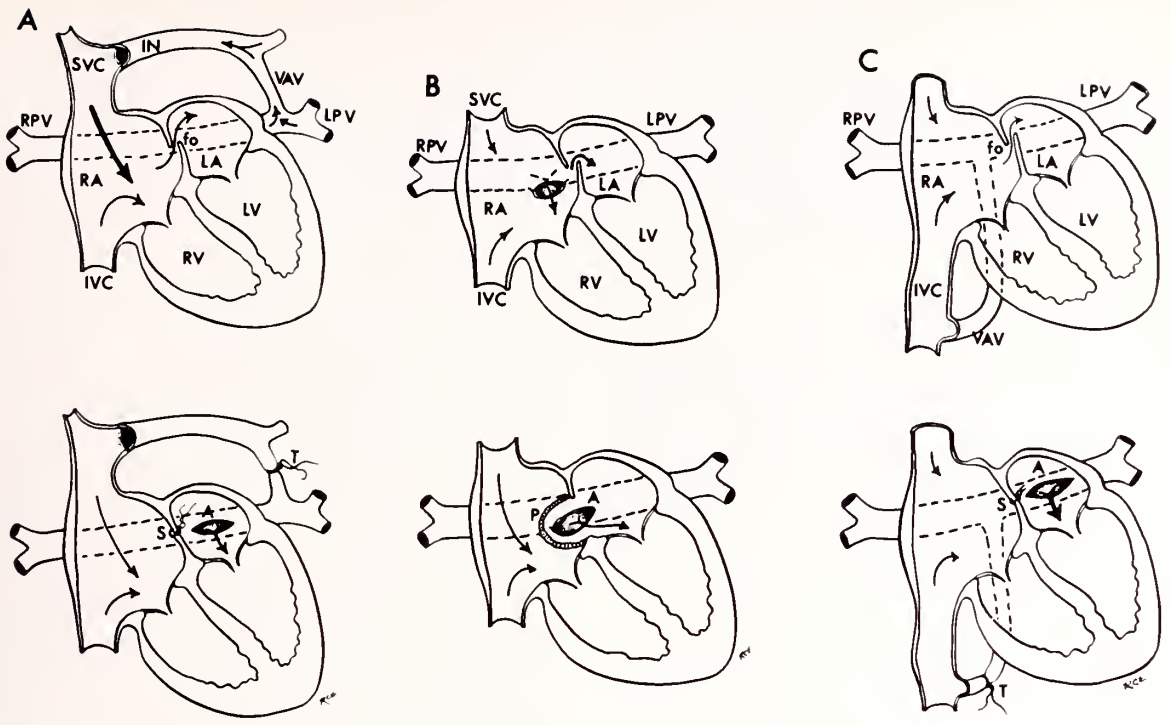


FIGURE 2. Total Anomalous Pulmonary Venous Return.

A. Supracardiac: Blood from the pulmonary veins (RPV & LPV) flows via a verticle anomalous vein (VAV) into the innominate vein (IN) and then to the right atrium (RA). Thus, all venous blood, both systemic and pulmonary, returns to the right atrium. The only blood reaching the left atrium passes via the patent foramen ovale (FO).

The lower diagram depicts the operative procedure. The pulmonary veins are anastomosed (A) to the posterior wall of the left atrium, the anomalous vein is tied (T) and the foramen ovale is sutured (S).

B. Cardiac: The pulmonary veins (RPV & LPV) empty directly into the right atrium (RA). A small amount of mixed systemic and pulmonary venous blood reaches the left atrium via the foramen ovale.

The operative procedure is depicted in the lower diagram. The pulmonary venous opening into the atrium is enlarged (A), and a portion of the atrial septum is excised and replaced with an oblique dacron patch (P) to shunt the pulmonary venous blood into the left atrium.

C. Infracardiac: Blood from the pulmonary veins (RPV & LPV) empties via a verticle anomalous vein (VAV) into the inferior vena cava (IVC) or one of its branches. A small amount of mixed systemic and pulmonary venous blood reaches the left atrium via the foramen ovale (FO).

The operation correction of this lesion is depicted in the lower diagram. The pulmonary veins are anastomosed (A) to the posterior wall of the left atrium, the anomalous vein is tied (T), and the foramen ovale is sutured (S).

this small shunt and require a Blalock-Hanlon shunt several months later.

Tricuspid and Pulmonic Atresia

(Fig. 1C). In this anomaly the tricuspid valve is either atretic or severely stenotic, and venous blood in the right atrium passes through an atrial septal defect into the left atrium thus producing cyanosis. The right ventricle and pulmonary artery are also hypoplastic so that even if the tricuspid valve could be enlarged there would still be inadequate blood flow to the lungs.

These infants are cyanotic at birth and the degree of cyanosis and prognosis depends on the amount of blood, if any, passing through the right ventricle into the pulmonary artery. As the patent ductus closes, total pulmonary blood flow decreases and the infant dies. The presence of a murmur is variable. The lung fields are clear on the x-ray due to diminished pulmonary blood flow. The EKG shows left axis deviation and left ventricular hypertrophy —a contrast to severe Tetralogy of Fallot which otherwise has a similar clinical and x-ray appearance.

The only hope for survival is an aorto-pulmonary artery shunt to increase the pulmonary blood flow. (Fig. 5) A few total corrections have been performed in the milder form of this lesion in which the right ventricle is merely under-developed and not truly atre-

tic. The ASD is closed with a perforated patch which slowly shuts off the right to left shunt. As the perforations gradually close, the right ventricle has time to enlarge and accept the increased load. In those infants with the severe form of tricuspid or pulmonic atresia no total correction can be performed at this time, except perhaps cardiac transplantation.

Truncus Arteriosus

(Fig. 1D). At an early stage of embryonic development the heart is a single tube and the cranial portion, the truncus arteriosus, subdivides into the aorta and pulmonary artery. When the truncus fails to divide, the upper portion of the interventicular septum is absent and both ventricles empty into a single large vessel—the persistent truncus arteriosus. The right and left pulmonary arteries arise directly from the truncus at varying sites. Usually the total pulmonary blood flow is increased, and, due to the high pressure, irreversible pulmonary hypertension occurs within one or two years.

Infants with this lesion are mildly cyanotic at birth and the cyanosis increases as pulmonary hypertension decreases pulmonary blood flow. Chest x-ray reveals a globular-shaped heart and the pulmonary vascular markings are usually increased. The EKG indicates both left and right venticular hypertrophy.

Infants with truncus arteriosus and increased pulmonary blood flow should have a constricting band placed around each pulmonary artery. This decreases pulmonary blood flow and lowers the pressure in the distal pulmonary artery, thus preventing irreversible pulmonary hypertension. Total correction has been successful with homograft from the anterior wall of the right ventricle to the pulmonary arteries which are excised from the truncus[7]. The mortality rate is high and the operation must be performed before pulmonary hypertension develops.

Total Anomalous Pulmonary Venous Return

(Fig. 2 A-C). In this lesion the pulmonary veins combine to form a large transverse anomalous vein lying posterior to the heart. Rather than draining into the left atrium, the pulmonary venous blood all returns to the right side of the heart by one of three routes: Into

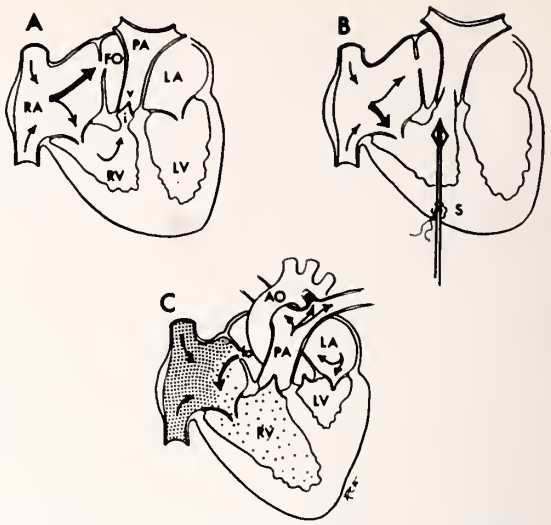


FIGURE 3. A. Pulmonic Stenosis: Stenosis of the pulmonic valve (V) or infundibulum (i) causes increased pressure in the right ventricle (RV) and right atrium (RA). The increased right atrial pressure results in systemic venous blood being shunted into the left atrium via the foramen ovale (FO).

B. Operative correction is performed by inserting a valvulotome through the wall of the right ventricle within the confines of a pursestring suture (S), expanding the blades to 4-8 mm., and thrusting the blades through the stenotic valve to enlarge it.

C. Underdeveloped Left Heart: The left ventricle (LV) and the mitral and aortic valves are atretic. Pulmonary venous blood returning to the left atrium (LA) passes via the foramen ovale (FO) into the right atrium. The only blood reaching the aorta is by reversed flow via a patent ductus.

the superior vena cava, usually via the innominate vein; into the right atrium either directly or via the coronary sinus; or, into the inferior vena cava or one of its branches. Thus all venous blood, both systemic and pulmonary, enters the right atrium. The only way blood can enter the left heart is via an atrial septal defect and by retrograde flow through a patent ductus arteriosus.

If there is no pulmonary venous obstruction, the infants are only mildly cyanotic. They have right heart failure due to massive blood flow to the lungs. The x-ray shows cardiac enlargement with increased pulmonary vascularity. The EKG shows right axis deviation and right ventricular hypertrophy. There is usually a systolic murmur along the upper left sternal border due to the large flow across the pulmonic valve. The untreated prognosis varies with the site of anomalous return—those emptying directly into the right atrium may (Fig. 2B) survive several months or even years,

but those infants with longer routes of return have pulmonary venous obstruction and usually die within a few months. (Fig. 2A and 2C)

Total correction must be performed with extracorporeal circulation at an early age. In the supra and infracardiac types of T.A.P.V.R. the transverse anomalous vein is anastomosed to the posterior wall of the left atrium, the anomalous vein to the systemic circulation is ligated, and the foramen ovale is closed. In the cardiac type T.A.P.V.R. the opening into the right atrium is enlarged and a dacron patch is sutured over the opening to shunt the pulmonary venous blood through the enlarged atrial septal defect into the left atrium.[8]

Pulmonic Stenosis and Atrial Septal Defect

(Fig. 3A). In this lesion there is stenosis of the pulmonic valve, with or without narrowing of the annulus and infundibulum, and right ventricular hypertrophy. The right ventricle generates extremely high pressure, 150 mm Hg or more, and the secondary increase in right atrial pressure results in a right-to-left shunt through an atrial septal defect or a patent foramen ovale. If the pulmonic stenosis is severe, almost all blood is shunted into the left atrium and the infant is very cyanotic. EKG shows severe right ventricular hypertrophy and right axis deviation. Chest x-ray reveals diminished pulmonary vascular markings and cardiac enlargement. Usually a systolic murmur is present along the left sternal border due to flow through the stenotic pulmonic valve; however, with severe stenosis and little flow through the pulmonic valve, the murmur may be absent. It is sometimes difficult to distinguish severe pulmonic stenosis from Tetralogy of Fallot, and diagnosis must be made by cardiac catheterization.

Surgical treatment consists of opening up the pulmonic valve either by closed valvotomy, or by hypothermia with inflow occlusion and direct vision valvotomy. In infants we prefer closed valvotomy. (Fig. 3B) A pursestring suture is placed in the right ventricle near the apex and a Brock valvulotome is inserted within the confines of the suture into the right ventricular cavity. The blades are then opened to a diameter of four to eight mm and thrust through the valve which has a preoperative diameter of only one or two mm. This increase in the valve orifice area produces a dramatic increase in pulmonary blood flow, a fall in right ventricular pressure, and reduces or eliminates the right-to-left shunt at the atrial level. Although the initial results of closed pulmonic valvotomy are dramatic, residual stenosis is usually present and the infant may require open valvotomy with cardiopulmonary bypass at a later age.[9]

Underdeveloped Left Heart

(Fig. 3C). This lesion is atresia or hypoplasia of the left ventricle, and the mitral and aortic valves.[10] Most of the blood returning to the left atrium passes through a patent foramen ovale into the right atrium. The mixture of

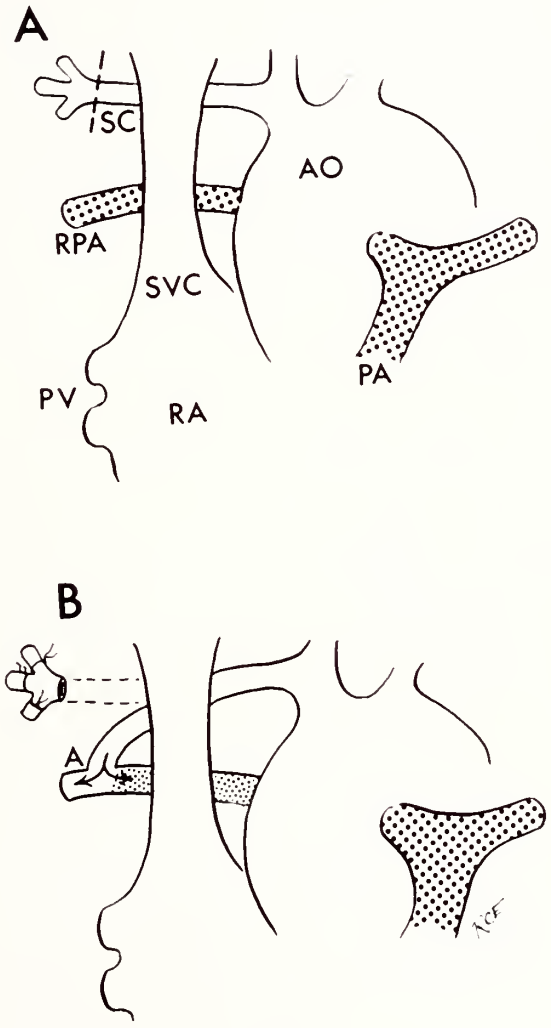


FIGURE 4. Blalock-Tausig Shunt.

A. The subclavian artery (SC) is divided near its distal end.

B. The subclavian artery is then anastomosed to the right pulmonary artery to increase the total blood flow.

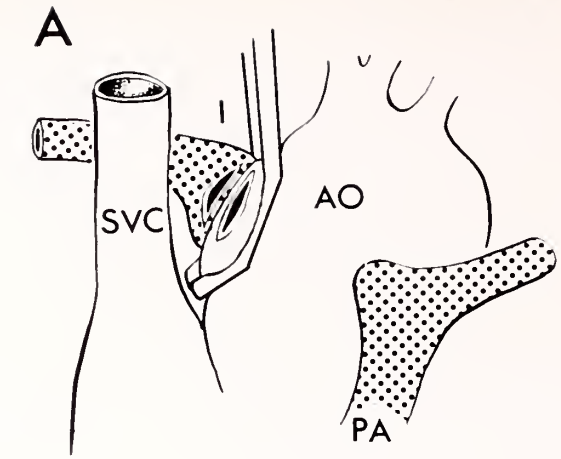


FIGURE 5. Aortic-Right Pulmonary Artery Shunt.

A. A clamp is placed which totally occludes the right pulmonary artery (PA) and tangentially occludes a portion of the ascending aorta (AO). Parallel 5 mm. incisions (I) are made in the two vessels.

B. After the incisions are sutured together and the clamp removed, an anastomosis (A) has been created which increases the blood flow into the pulmonary artery.

systemic and pulmonary venous blood then passes into the pulmonary artery and the only blood that reaches the aorta is that which passes by reversed flow through the patent ductus arteriosus. As the ductus closes the infant dies.

These infants may appear normal at birth, but within 48 hours develop heart failure and show signs of shock—vasoconstriction with weak or absent pulses. EKG demonstrates right ventricular hypertrophy and the pulmonary vascular markings are increased on chest x-ray. There may be a systolic flow murmur in the pulmonic area.

There is no palliative or corrective operation for infants with underdeveloped left heart. Rarely, the aortic or mitral valve alone is stenotic and the left ventricle merely small rather than atretic—in these cases aortic or mitral valvotomy may be performed as in pulmonic stenosis.

Discussion

A discussion has been presented of the surgical management of seven precise cyanotic heart anomalies in infants. However, occasionally the cardiac lesion is not quite so precise as described—they vary in severity and combination of lesions. The timing and type of surgical procedure must be tailored to fit the individual lesion—thus the need for early and accurate diagnosis.

The operative procedure is likewise seldom as simple as diagrams indicate. Suturing infant vessels can be compared to anastomosing two pieces of wet spaghetti while they contract 100 times per minute. Cyanotic infants do not tolerate operation well and, in addition to technical problems, the surgeon must combat three enemies: hypothermia, acidosis, and

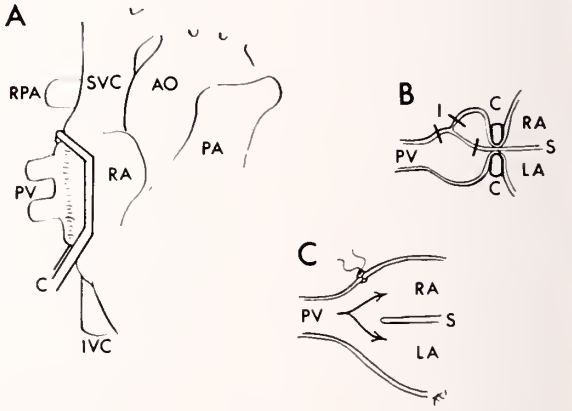


FIGURE 6. Blalock-Hanlon Shunt. A. A clamp (C) is placed to tangentially occlude a portion of both the right and left atria and the right pulmonary veins (PV).

B. Side view shows clamp (C) excluding a portion of the right and left atria (RA & LA) with the intervening septum (S). Parallel incisions (I) are made in the excluded RA & LA, and a portion of the atrial septum is excised.

C. After the incision is sutured and the clamp removed, an atrial septal defect has been created to increase mixing between the atria, and the right pulmonary veins emptying into both atria.

blood volume changes. A few degrees drop in temperature will cause slowing of cardiac rate and output. The operating room must be warm (85°F), a heating pad on the table, extremities wrapped and skin preparation brief and with warmed solution. If these precautions are taken, rather than thrusting the wet, naked infant into the air-conditioned operating room, body temperature can be maintained. A central venous catheter is inserted both for intravenous fluid administration and periodic pH determinations. Most cyanotic infants are mildly acidotic (pH 7.20-7.30) and often severe acidosis ensues with the insult of anesthesia and operation. Frequent doses of intravenous sodium bicarbonate, 1-3 meq., are required. Also, one must remember that young infants have a blood volume of 300cc or less. Thus a 30 or 40cc blood loss, or the sudden infusion of 50cc of saline represents a life-threatening change in blood vloume. Precise intake and output must be recorded.

Finally the physician need no longer view the "blue baby" with despair. Although not all cyanotic infants can be salvaged, accurate diagnosis and early operation can give many of them a normal life expectancy. In what other area of medicine can the physician anticipate 70 or 80 year survivors?

References

1. Blalock, A. and Taussig, H. B.: The Surgical Treatments of Malformations of the Heart in which there is Pulmonary Stenosis or Pulmonary Atresia. *J.A.M.A. 128*:189, 1945.

2. Cooley, D. A. Hallman, G. L.: Intrapericardial Aorto-Right Pulmonary Artery Anastomosis. *Surg., Gynec, & Obstet, 122*:1084, 1966.

3. Noonan, J. A., Nadas, A. S., Rudolph, A. M. and Harris, G. B. C.: Transposition of the Great Arteries. A Correlation of Clinical, Physiologic and Autopsy Data. *New Eng. J. Med.* 263: 592, 1960.

4. Mustard, W. T.: Successful Two-Stage Correction of Transposition of Great Vessels. *Surgery* 55:469, 1964.

5. Blalock, A. and Hanlon, C. R.: The Surgical Treatment of Complete Transposition of the Aorta and Pulmonary Artery. *Surg., Gynec. & Obstet.* 90:1, 1950.

6. Rashkind, W. J. and Miller, W. W.: Creation of Atrial Septal Defect Without Thoracotomy: Palliative Approach to Complete Transposition of Great Arteries. *J.A.M.A.* 196:991-992, 1966.

7. Wallace, R. B., Rastelli, G. C., Ongley, P. A., Titus, J. K. and McGoon, D. C.: Complete Repair of Truncus Arteriosus Defects. *J. Thor. Cardiovasc. Surg. 57*:95, 1969.

8. Cooley, D. A., Hallman, G. L. and Leachman, R. D.: Total Anomalous Pulmonary Venous Drainage. *J. Thorac. Cardiov. Surg.* 51:88, 1966.

9. Brock, R.: The Surgical Treatment of Pulmonary Stenosis. *Brit. Heart J.* 23:337, 1961.

10. Noonan, J. A. and Nadas, A. S.: The Hypoplastic Left Heart Syndrome. *Pediat Clin. N. Amer. 5*:1029, 1958.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

A Study of Cholecystectomies in a Small Community Hospital

ROMEO S. BERARDI, M.D.*

McDowell, Kentucky

The results of 116 cholecystectomies, performed in a four and one-half year period, are discussed. Morbidity was 15.5 percent and mortality zero percent. Very careful individualization is emphasized in choosing early operation for acute cholecystitis.

CHOLECYSTECTOMY is by far the most commonly performed operation in this 60 bed hospital. During the considered study period, 116 cholecystectomies have been done as compared to 108 inguinal hernia repairs, 84 T & A's, 61 appendectomies and 57 gastric procedures for chronic duodenal ulcer.

This study covers a four and one-half year period (July, 1964-January, 1969) and is intended to analyse the results of cholecystectomy as obtained in a small community hospital. The patients included in this report were treated by one board certified surgeon and/or surgical residents under the latter's supervision.

Clinical Data and Results

One hundred sixteen cholecystectomies were performed for acute or chronic cholecystitis, all having cholelithiasis. Twenty-eight or 24.1 percent had a concomintant common duct exploration. The youngest patient was 17 and the oldest 86 with a median age of 53.9. There were 98 females and 18 males giving an approximate ratio of 5.4:1. Seventy-eight or 67.1 percent were over the age of 50. Of the 28 having choledochostomy, 22 or 81.1 percent resulted in positive findings (stones).

The post operative complications were as follows:

Ileus	1
Pneumonia	3
Wound infection	8
Wound seroma	7
(The differentiation between wound infection and seroma was based on bacteriologic results of wound cultures.)	
Cardiac failure	1
Wound dehiscence	1
Metabolic acidosis	1

This accounted for 22 complications occurring in 18 patients. Eleven or 50 percent of the complications occurred when the common duct was explored. Ninety-three and one-half percent occurred in patients over the age of 50. The overall morbidity rate was 18.9 percent but when corrected to the number of patients involved, it results in 15.5 percent. Four infections (stitch abscesses) and three seromas (stitch seromas) of the wound were of very minor degree. All gall bladder beds were drained and T-tube drainage was established in all explored common ducts.

The following indications necessitated choledochostomy: Jaundice or the history of jaundice, 13; palpable stones in the common duct, four; associated pancreatitis, five; size (greater than 1.2 cm.) and appearance of common duct, three; associated purulent cholangitis, one; and biliary "mud" associated with multiple small stones in the gall bladder with a dilated cystic duct, two. These represented the primary indications for choledochostomy, some patients having more than one indication.

Of the six negative choledochostomies, three occurred in patients with a history of jaundice, two in associated pancreatitis and one with small multiple gall bladder stones associated with a dilated cystic duct.

Pathologic diagnosis of all gall bladders was obtained and revealed either acute, sub-

*Chief of Surgery, Daniel Boone Clinic, McDowell Regional Hospital

acute, or chronic cholecystitis. All had stones. Two were considered to have mild cholecystitis but both were associated with cholesterolosis.

No attempt was made in this report to separate those cases treated as "semi-urgent" from the elective, but suffice it to say that of the entire group, six were operated on within 72 hours after admission with a diagnosis of acute cholecystitis. All six had wound complications in the postoperative period.

The average hospital stay was 15 days with the shortest five days, and the longest 36 days. The mortality rate was zero percent. All patients have been followed to date, being recalled at three, six, 12, 24, 36, 48 and 54 months. The median follow-up period is 16.8 months.

No patient has required re-operation for "post cholecystectomy syndrome". Two of the 116 were operated on four and one-half and two and one-half years after a vagotomy and antrectomy for chronic duodenal ulcer. Both gall bladders were found to be normal at the time of gastric surgery.

Discussion

Cholecystectomy is an extremely common operation and it is estimated that approximately 350,000 such procedures are performed in this country annually.[1] This procedure represented 6.1 percent of all general surgical operations performed during the considered study period, excluding operative gynecology and obstetrics.

Our results show a somewhat higher female/male ratio (5.4-1) than is usually reported.[2,3] This we feel can be partially explained by the fact that women in this area have a less hazardous life than men, most of whom are coal miners.

We were somewhat dismayed at what we considered to be a relatively high morbidity rate (18.9 percent). However, 67.1 percent of our patients were over the age of 50 and it is well known that morbidity and mortality in this age group is indeed high.[4] Ninety-three and one-half percent of the complications occurred in patients over 50 and 50 percent in patients having common duct exploration. Although there were no deaths in this series, Glenn reports a mortality of 9.6 percent in patients past 50 years of age having common duct exploration compared to a mortality of 1.5 percent in patients under 50.[4] In this study 24.1 percent had a choledochostomy. This figure approximates other reported series,[5,6] although positive common duct finding (stones) in this study was somewhat higher (81.1 percent).

Admittedly our experience with early operation in acute cholecystitis is quite limited, but it should be noted that the six patients in this study so treated all developed postoperative wound complications. This is not to imply a negative attitude toward early operation in acute cholecystitis, but only to emphasize our feeling that very careful individualization must be exercised in the choice of this policy in small community hospitals.

Summary

A study of 116 cholecystectomies in a four and one-half year period performed in a small community hospital has been presented. The corrected morbidity rate was 15.5 percent and the mortality rate zero percent. Very careful individualization is emphasized in choosing early operation for acute cholecystitis in small community hospitals.

References

1. Madden, J. L. et al: "Considerations in surgery of the common duct." *Current Problems In Surgery*. Year Book Medical Publishers, Inc. Chicago, May, 1968.

2. Colcock, B.P. and McManus, J.E.: Experiences with 1356 cases of cholecystitis and cholelithiasis. *Surg. Gynec. & Obst.*, 101: 161, 1955.

3. Rosi, P. A. and Midell, A. J.: Acute cholecystitis. *S. Cl. North America*. 47: 147, 1967.

4. Glenn, F.: Common duct exploration for stones. *Surg. Gynec. & Obst.* 95: 431, 1952.

5. Glenn, F. and Beil, A. R.: Choledocholithiasis demonstrated at 586 operations. *Surg. Gynec. & Obst.* 118: 499, 1964.

6. Appleman, R. M., Priestley, J. T. and Gage, R. P.: Cholelithiasis and Choledocholithiasis. *Mayo Clin. Proc.* 39: 473, 1964.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT SECTION

1969 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 23, 24, 25**

Fill Out and Mail to:

T. R. MARSHALL, M.D., Chairman

Committee on Scientific Exhibits

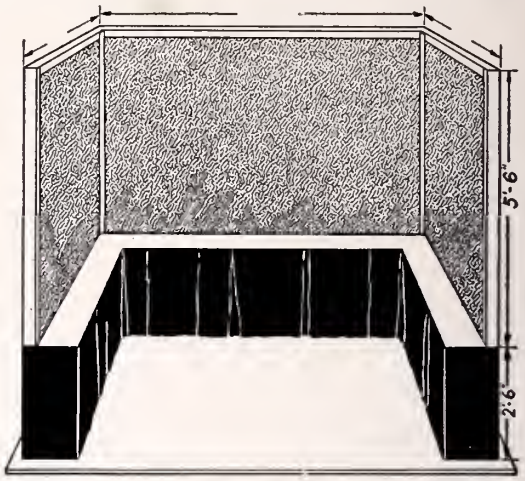
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1969

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?).....

 Institution (if desired):

 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 50 Words to this blank)
5. Exhibit will consist of the following: (Check which)

 Charts and Posters.... Photographs.... Drawings.... X-rays

 Specimens.... Moulages.... Other Material.....
 (Describe)
6. Booth Requirements:

 Amount of total wall space needed?

 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided to you in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 40202, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
56569

The trouble with women...



frequently is men

FLAGYL®
brand of metronidazole

Cures Trichomonal Infection in Both

Although *Trichomonas vaginalis* infection occurs in only 5 to 10 per cent* of men, careful diagnosis will demonstrate the condition in about half of all husbands of infected women. Nine investigators* reported an average incidence of 50.8 per cent in exposed consorts.

Many clinicians have achieved a high degree of success in treating trichomonal vaginitis only after they have recognized the importance of sexual partners in perpetuating the infection. Crowley* has asserted, "it was not until we acted on this key premise that we were able to obtain positive and lasting results in our management of recurrent vaginal trichomoniasis."

Simple ten-day oral treatment with Flagyl virtually assures elimination of established trichomonal infection in men. In twenty-two of twenty-seven studies* data on the results of treating male patients revealed that all men treated with Flagyl were cured.

Indications: Flagyl is indicated in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: *In women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

*Complete list of references on request.

SEARLE

Research in the Service of Medicine



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray



When pollens fly, just one or two squirts of NTz in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTz helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTz Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1%, antihistamine
Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTz should be repeated every three or four hours as needed. NTz is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (1289M)

Winthrop

SPECIAL ARTICLES

Health Manpower—Mostly! †

DONALD E. WOOD, M.D.*

A STORY is told that Will Rogers, the nation's favorite humorist 40 years ago, was having dinner with several high-ranking officers of the Army and Navy. Two admirals across the table from him were talking on and on about the growing importance of submarine warfare.

Finally having enough of it, Rogers casually remarked that he didn't understand how submarines could be any problem since all of them could be driven out of the water by simply boiling the ocean.

The naval officers, of course, were shocked . . . and politely demanded to know how that could possibly be done.

"I don't know," Rogers said. "I've given you the solution. Working out the details is your job."

That story, which I understand is probably true, illustrates something all of us have seen many times . . . and continue to see almost every day. It is offering an over-simplified, single-dimensional solution to a complex, multi-faceted problem.

I think most people do it seriously now instead of as a joke. We as individuals are guilty of it. Groups supporting a cause are guilty of it. And yes, so are governments. Whoever does it, of course, the objective always is to show how to bring about some very good, some very desirable result . . . with a bare minimum of thought and effort and without going to any of the trouble to find the real causes or to understand the real ramifications of the problem.

People who thought alcohol was terrible once believed they could cure all the evil they saw in beer, wine and liquor simply by having them declared illegal.

However, three generations earlier, people who hated slavery—and who were dead right to oppose it—thought all they had to do to solve the social, the political, the racial and economic problems it caused was to set the slaves free.

In communities large and small, many people today—dissatisfied with the quality of education their children get—think they can improve it just by building a new school. I'm sure you know some. Also, promises flow every day from pulpits and city halls that juvenile delinquency in a given area will vanish as soon as a new playground is dedicated. It helps, I'm sure, but is it the answer?

At the personal level, I'm sure all of us have known men who had the delusion that a rotten job would become exciting and happy if they only got a good raise. Even more tragic are couples who decide that the way to save their crumbling marriage is to have a baby. You know some!

Most people appear to have become accustomed to that kind of thinking. You really can't blame them. The fact is, the problems of life and of society are so immense today, and so complex, that it is impossible to understand them fully. I know I don't.

And they have multiplied so rapidly that they constantly pile up on every side until you can't even keep track of them.

So, for each one, people look for a simple solution they can see and that they can understand. They applaud the man, the group or the government that offers it. The most unfortunate thing about it is that nothing is learned when one easy solution is tried and falls flat on its face. Instead of digging deeper for the real causes of the problem and of its failure, they wait for someone else to propose another simple solution.

In the last few years—and with increasing intensity today—the medical profession and the whole health care field have become outstanding victims of that kind of thinking.

There are a great many serious, complicated and far-reaching problems that affect the health care field today. Those of us who are physicians . . . and particularly those of us physicians who are active in medical organizations . . . as you all here are today . . . have done a great deal of thinking and talking about them. We have devoted millions of man-hours to understanding the problems . . . identifying their causes . . . and devising solutions for them.

But there's one thing in particular that I've noticed. A lot of doctors are upset—including me—because the people of this country are not really looking to the medical profession for leadership in bringing about solutions to medical and health problems.

†*Presented at the 1969 Interim Meeting of the Kentucky Medical Association, March 27, Lexington*

**Member of the Council on Health Manpower, American Medical Association*

I can tell you why!

It is a dramatic manifestation of what I was talking about.

The difficulty is that the medical profession hasn't come up with *one single easy solution* to any of these problems. We couldn't, because we are too busy digging out the facts. We are too much aware of the tremendous difficulties that are involved.

However, people who have nothing to do with medical and health care do not labor under that great disadvantage. They have come up with the simple solutions. They have told us to boil our ocean, and then left it strictly up to us to figure out how. And the eager public is looking to those outsiders for leadership because they are the people with the answers.

Let me give you just a couple of examples of the easy solutions available for problems we have been wrestling with for years.

There are shortages of manpower in the field of medical and health care. What's the simple solution? Produce more doctors? Hire more allied people? Now why couldn't we think of that?

About those new doctors we're supposed to produce—never mind the nine to 14 years it takes to turn a young man or woman from a high school graduate into a physician, depending on the choice of specialty, if any.

Never mind that in order to turn out substantially more graduates, you're going to need substantially more medical school plants. And never mind the 80 to 100 thousand dollars per student that it costs to build a medical school plant and equip it.

Never mind finding out whether people are willing to pay the higher taxes necessary to provide the higher appropriations from legislatures so states can create new educational facilities. When schools are built or expanded, never mind where the faculty is going to come from . . . or how their salaries are to be paid.

Now, about those allied professionals and technicians—all you have to do is go hire more of them. Never mind where they're going to get the special education and training they need for such highly skilled jobs.

Never mind the fact that those jobs historically carry notoriously poor wage levels. Or that when you raise the wage levels to attract more people, you drastically increase the cost of medical and health care.

Ignore all of the problems involved in trying to establish avenues of vertical movement so that a person can look forward to a promotion, rather than spending the rest of his life at exactly the same level.

When you're supporting easy solutions, you don't worry about details. You've got a problem with health manpower? Then get more of it. Period.

There is another problem of rising cost of medical and health care. The simple solution? Freeze physicians' fees and hold down the cost of hospital care. Isn't that a beauty?

Ignore inflation. Forget about the fantastically increasing demand for medical and health services . . . and all of the factors contributing to that increase.

Ignore all of the government programs that have poured billions of new dollars into a field that was already over-burdened to provide many more services for many more people without doing anything to increase the supply of those services.

When you're talking about hospitals, forget about all the sophisticated new equipment they must have. Ignore the increased numbers of skilled professionals and technicians they have to employ . . . as well as the higher salaries and wages they have to pay.

Just solve the problem of rising costs by freezing doctors' fees and holding down hospital costs.

In these very easy-sounding, one-sentence solutions, there is a tremendous advantage . . . and an equally tremendous disadvantage.

The advantage in the simple solution is to those who propose them. It gives them an aura of leadership because they have said how the problem can be solved. But it relieves them of any responsibility because they have passed the job to the medical profession and the health field.

In a year or two . . . or even sooner . . . if the problem is not solved, they can rise in righteous indignation and declare that the health professions have failed.

The disadvantage, obviously, falls to the medical profession, its allies and, ultimately, to the public. Because having heard how easy the solution is . . . and that it is somebody else's responsibility to do the job . . . the public turns its attention away from that problem, assuming it will be taken care of.

Probably our greatest challenge right now, as a medical profession, is not only to devise workable solutions to the problems that affect us, but to sell the public the truth: that there are no simple, quick, easy solutions; and that whatever is done will require the cooperation of everyone.

Perhaps an outstanding example of a problem that will require national effort is that of medical and health manpower. There are others I could talk about, but I'd like to concentrate on this one for two reasons:

First, I'm working with it as a member of the AMA Council on Health Manpower. And second, if we ever solve the problems of manpower, many of the other problems will virtually dissolve.

If there were enough physicians and health manpower—and only the good Lord knows what "enough" would be—there wouldn't be any significant problems of crowded waiting rooms, of hurried or impersonal handling of patients by doctors with too many people to see every day, or of difficulties finding a physician at any hour of the day or night.

There also wouldn't be any big problems of locating physicians in small towns or rural areas as well as in cities and suburbs, or even of providing more

easily available care in slum areas or any other geographical location.

The natural laws of selection and competition would take care of those things. Right now, however, we don't have enough physicians or enough health manpower. When we start thinking about how to correct that situation, we find a great many considerations worthy of our attention.

Is there really a shortage in the supply of health services, or is the problem an excess of demand? The answer is some of both, but neither can be ignored.

Where there is a shortage of patient care services, is that really the problem . . . or can it be traced also to shortages in the areas of medical education, research and control of environmental health conditions?

Regarding the latter point, there is a serious question whether any kind or quantity of care can really provide good health for people who live in an environment that breeds disease. Improving health in the slums means eradicating the slums—and that is a social problem, not a medical one.

The medical profession cannot be held responsible for the good health of people who are forced to share their living, sleeping and eating quarters with rats and insects.

In connection with the poor, and with other segments of our population, we can ask further questions: Where people are unable to get immediate medical attention, is it really because there is no physician nearby?

Or is the problem caused just as much or more by lack of public transportation, lack of knowledge about how to get care, inhibitions against seeking help because of poverty, superstition or fear?

And how much shortage is created throughout society by insurance plans that encourage hospitalization and fill existing facilities to capacity? How efficiently are today's medical and health people used?

For example, how much time does a physician spend doing things that he really shouldn't do . . . things that don't require his level of professional knowledge, judgment and skill? And how often is the same thing true of other professionals and technicians?

Adding only 10 percent to the productivity of today's physicians would, in effect, add 30,000 physicians to the nation's resources. That's just about equal to the yearly production of 300 brand new medical schools.

The same increase in productivity for all health workers would add the equivalent of 350,000 skilled people.

Those are some of the questions the AMA's Council on Health Manpower is trying to answer. And they indicate areas in which we are trying to make progress.

More is being done about all of those things than just talking about them. Progress is being made in producing physicians and in making care available.

First-year medical student enrollment in 1967 was 9,500 in 94 schools. By 1970 it will reach 10,900 in 102 schools. Five new medical schools opened last fall and more are on the way, along with expansion of others.

The University of Oklahoma Medical Center's "Project Responsibility" is helping to provide health professionals and personnel in small towns and rural areas. Its first combination clinic, hospital and nursing home has been dedicated.

More than 100 communities around the nation have medical centers built and staffed by local effort through the Community Medical Assistance Program of the Sears-Roebuck Foundation and the AMA.

The Kansas Rural Health Plan is said to have put doctors and hospital facilities within a 20-minute drive of the remotest wheat field or cattle ranch in the state. The plan is supported by such diverse groups as the Kansas Medical Society, the University of Kansas Medical School, the state chamber of commerce, the CIO and the American Farm Bureau Federation.

It includes larger appropriations for expansion of the medical school, construction of medical centers in small towns through private financing, and the launching of traveling faculty teams to provide short courses in continuing education for doctors throughout the state. That last item overcomes the disadvantage of medical isolation that keeps many physicians from leaving the big cities.

Many other specific achievements could be listed, including those among the poor—both privately sponsored and projects of the federal government's OEO Program, in cooperation with local medical societies.

Much more remains to be done . . . and I think all of us realize there is more to the manpower problem than just hiring more people and turning out more doctors. There is more to the cost problem than freezing fees, wages and costs.

There is, in other words, more to driving out the submarines than boiling the ocean.

This is what we must tell the people, and make them not only believe it, but understand it and support it.

The job can be done. But it can only be done slowly . . . and it can only be done right . . . if the results are to be truly effective and long-lasting.

If we don't get this story across . . . while continuing to initiate and carry out programs that develop positive results . . . then we shall continue to be victims of public indignation for failing to achieve the simple goals outlined for us by other people who don't really know anything about our problems.

It is a challenge worthy of professionals!

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochlorid
In depression...
when words are not enoug

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

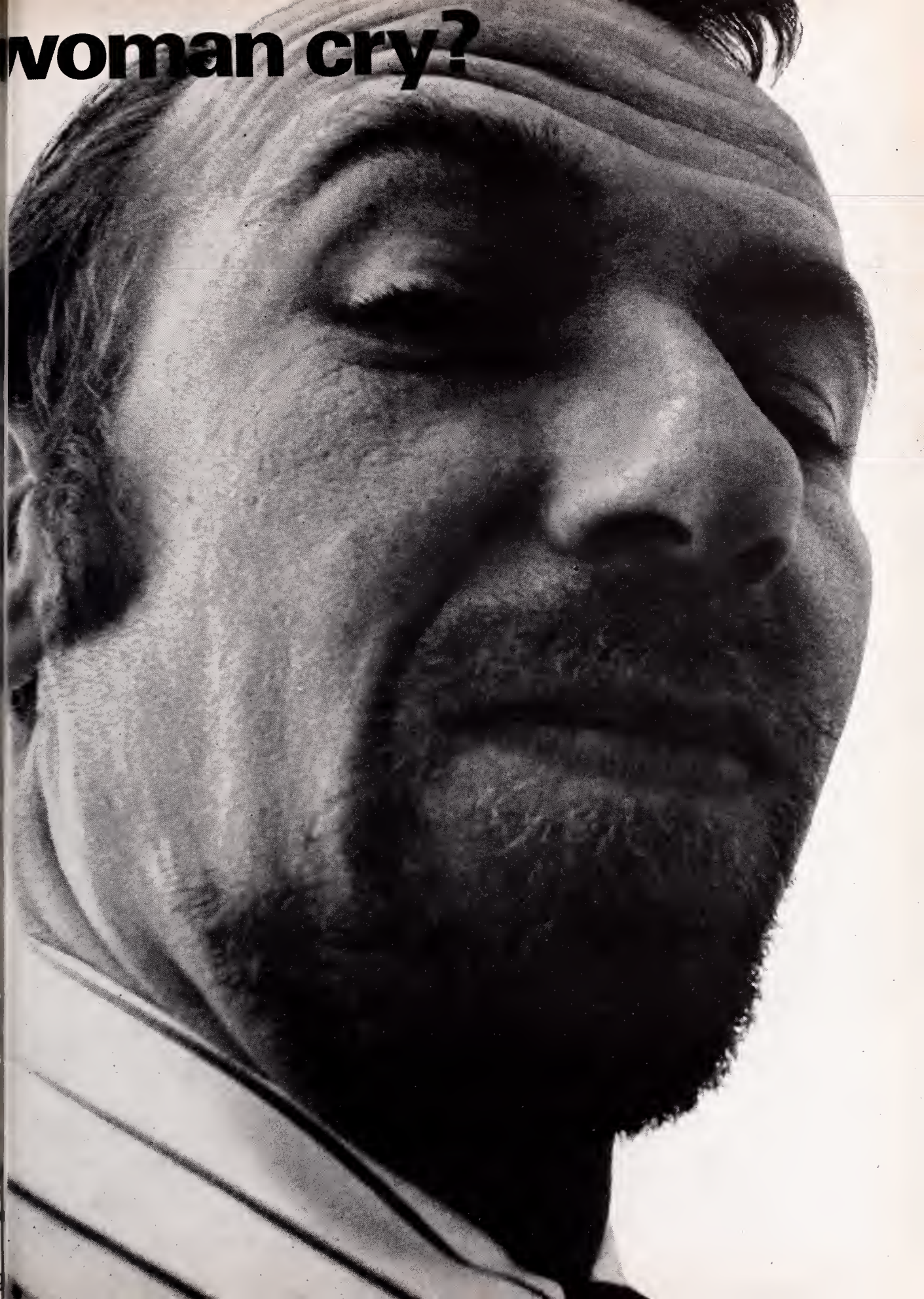
Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

woman cry?



EDITORIALS

Ulcerative Disease of the Bowel

IN MARCH 1962, we had two young men, ages 17 and 15 years, who presented with ulcerative disease of the bowel. Surgery was performed on both by the same surgeon in one week. The 17-year-old boy had a typical regional ileitis which showed sufficient involvement of the caecum and proximal colon so that resection of both segments of bowel was deemed advisable. The 15-year-old had ulcerative colitis of the proximal colon with involvement of the distal ileum. Both segments of bowel were resected. Both patients have done unexpectedly well during the past seven years with no major recurrence of their disease and have been able to pursue their educational program and to begin productive lives.

These two diseases have long been well recognized clinical entities. Diagnostic criteria and rational therapeutic regimens have evolved largely by trial and error since no accepted etiological basis for either is yet known. It is the occasional overlapping of the areas of gut involved in each disease which has often led to confusion.

During the past 10 years, interest has grown in another form of ulcerative disease, now generally called granulomatous colitis. Various other descriptive names have been used to designate a colonic involvement which pathologically appears more similar to regional ileitis than to the long recognized chronic ulcerative colitis. In revewing some of the literature, it would seem that the described differences in these three diseases may be sometimes more academic than practical, but one feels inclined to accept this as a rather distinct form of ulcerative disease of the bowel.

The anatomical changes of granulomatous colitis are similar to those in regional ileitis in that the entire intestinal wall is affected—thickened and rigid—rather than the mucosal lesions of ulcerative colitis. The caecum and proximal colon are more likely to be involved and to be associated with similar changes in the distal ileum. There are often long or short skip areas with normal bowel intervening between segments of ulceration. Constriction due to thickening of the bowel wall with resultant partial obstruction is relatively common, whereas it seldom occurs in the more usual chronic ulcerative colitis.

There is little difference in incidence of the disease between males or females. Generally, it is found among older patients than is expected in either regional ileitis or chronic ulcerative colitis and rarely occurs in the very young. There is no known difference in geographic or race distribution. It has apparently less frequent incidence than either ulcerative colitis or ileitis.

As in other forms of ulcerative diseases of the gut, bloody diarrhea is perhaps the most common symptom. Fever is irregular and may be intermittent. Abdominal cramping or pain, weight loss, malaise, and weakness are common complaints. It is thought by some observers that granulomatous colitis is more likely to smolder for a long time with annoying symptoms, such as rectal bleeding, fissures, or fistulae, before manifesting itself as an acute fulminating disease.

Physical, laboratory and X-Ray findings vary considerably. Abdominal tenderness has no constant pattern; a mass is felt less frequently than in regional ileitis. Sigmoidoscopic findings are perhaps less characteristic than in ulcerative colitis except when the frequently described "cobblestone" appearance is found, caused by areas of ulceration interspersed with normal mucosa. But this is not really a very

reliable differential finding. Radiological distinctions are not very clear. The proximal and transverse colon more often show changes; segmental involvement is more frequent; areas of constriction due to thickening of the entire colonic wall may render differentiation from localized malignancy difficult. If proctoscopic biopsy is taken, it is expected that the sarcoid reaction, which is found in a high percentage of cases of granulomatous colitis, may provide an important differential sign.

Complications of granulomatous colitis are principally anal lesions, which may actually be presenting evidences of the disease long before colonic changes are apparent, and fistulous tract formation. These fistulas more often extend from one section of gut to another and to adjacent organs, as the uterus and bladder, but they may pass to the abdominal wall or perianal skin. It is very like regional enteritis with its skip areas and fistulous tracts to adjacent loops of small bowel. Malignancy, however, is not feared as it is in ulcerative colitis; at least, to date, it has rarely, if ever, been reported. Toxic megacolon with paper-thin wall and hourly threat of perforation does not occur, apparently because of the thickened, more or less rigid bowel wall.

It is academic, but of considerable practical interest, to establish as firmly as possible a specific diagnosis of ulcerative bowel disease; although, when this is done, essentially the same medical therapy is most likely to be used. Regulation of physical activity and diet, sedatives and perhaps tranquilizers, drugs for symptomatic relief of pain and diarrhea, control of fever by antibiotics and of anemia by blood transfusions, are basic. Azulfidine, over a long period, apparently is more effective in chronic ulcerative colitis than in either regional enteritis or granulomatous colitis, but it is used because no other long-term medication seems superior. Corticosteroids are used to control acute fulminating symptoms in the same way —usually by slow intravenous drip. Used orally over a long period, the steroids seem less effective than in ulcerative colitis. Surgery is perhaps as often required in one form of ulcerative bowel disease as in the others—in granulomatous colitis it may be employed early in the course of the disease because of abscess or fistula formation or of obstruction. Surgical approach is often more conservative and total colectomy less often required. Recurrence of the disease in remaining portions of the bowel are similar to that in regional ileitis.

Tuberculous, amoebic and other infectious forms of ulcerative bowel disease constitute an entirely separate group. Granulomatous colitis has no known single etiological basis and seems to be related to the long-familiar ulcerative colitis and regional enteritis. It is expected that still other disease entities in this group may yet be identified.

SAM A. OVERSTREET, M.D.

Bibliography

1. Franz Goldstein: Current Management of Ulcerative Colitis. *Medical Times*. Vol. 95, 1967, pp. 448-459.

2. Arthur E. Lindner: Ulcerative Colitis — Make Sure It Is Not Granulomatous Colitis. *Consultant*. Vol. 8, Sept. 68, pp. 5-8.

3. Gerald Peskin; Eugene Edynak — *American Journal of Medical Science*. Vol. 253, Feb. 67, pp. 230-238.

4. W. C. McGarity; J. W. Ross; Earl Bobo; J. S. Schroder; J. L. Achord — *Annals of Surgery*. Vol. 167, No. 6, June 68, pp. 927-941.

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G.I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

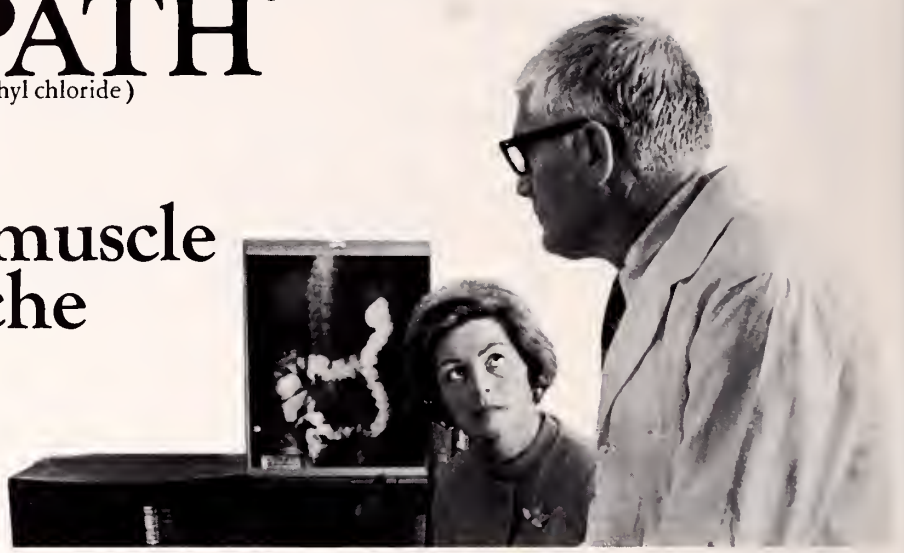
relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

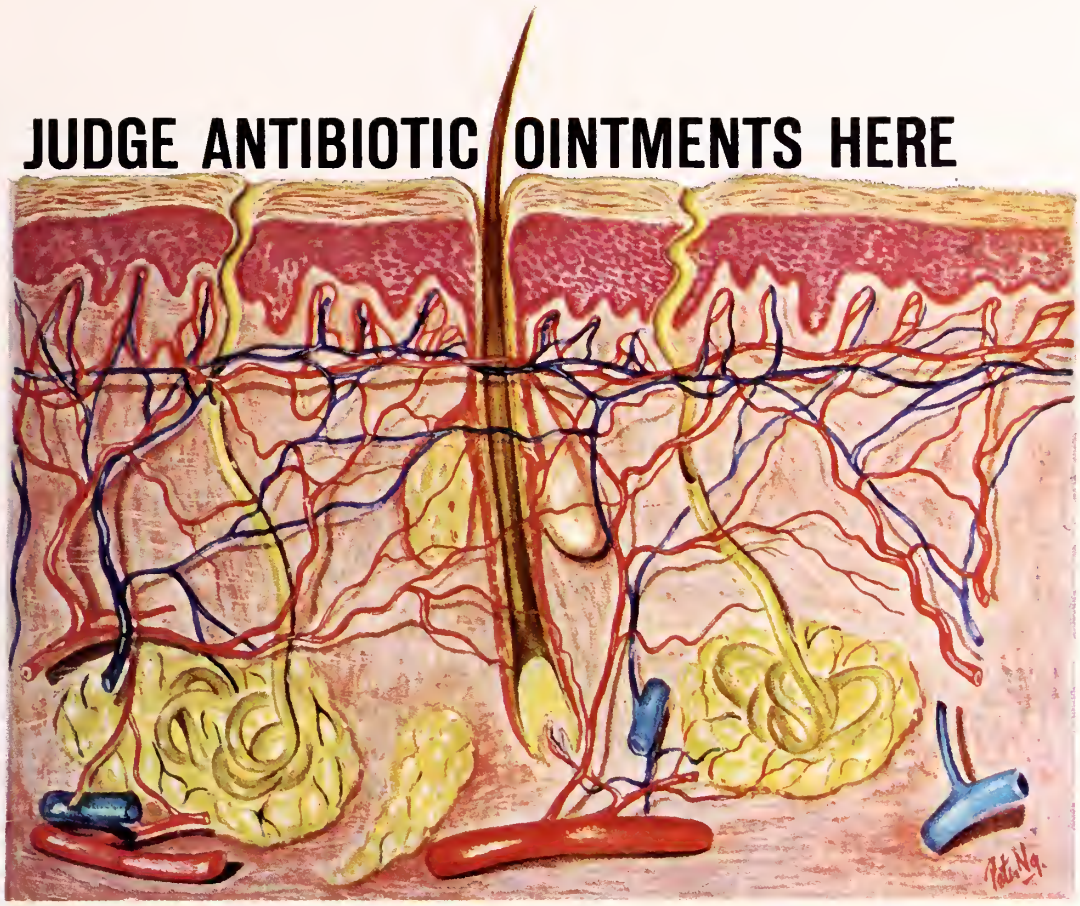
Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-

or here.



ed). Though generally not recommended, if mbination therapy with other psychotropics ems indicated, carefully consider individual armacologic effects, particularly in use of potiating drugs such as MAO inhibitors and enothiazines. Observe usual precautions in esence of impaired renal or hepatic function. radoxical reactions (*e.g.*, excitement, stimulaon and acute rage) have been reported in psyiatric patients. Employ usual precautions in eatment of anxiety states with evidence of imnding depression; suicidal tendencies may be esent and protective measures necessary. Varile effects on blood coagulation have been ported very rarely in patients receiving the ug and oral anticoagulants; causal relationip has not been established clinically.

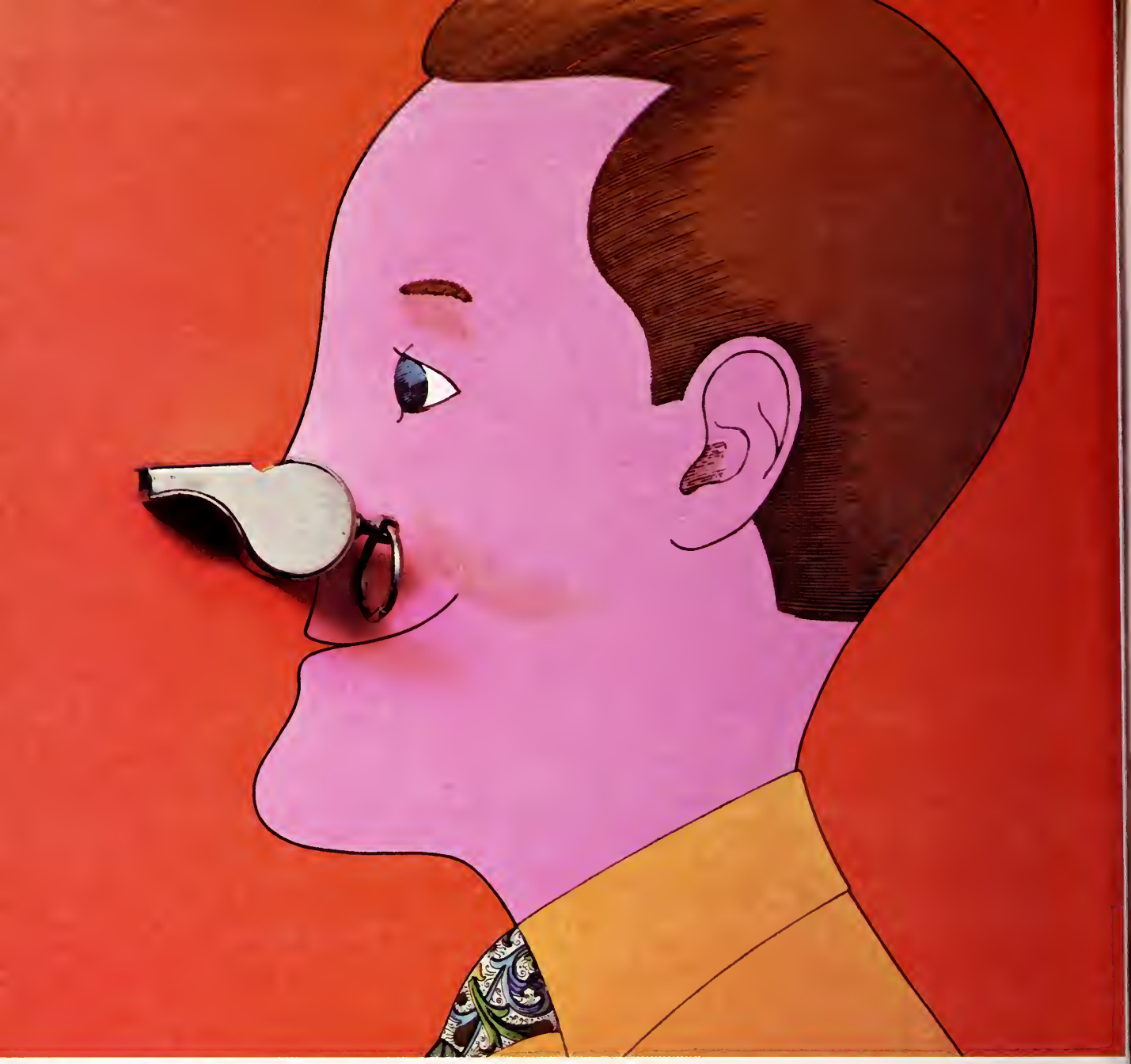
ADVERSE REACTIONS: No side effects or anifestations not seen with either compound one have been reported with Librax. When lordiazepoxide hydrochloride is used alone, owsiness, ataxia and confusion may occur, pecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics, and/or low residue diet.

two good reasons for prescribing

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



118th Annual Convention
AMA
NEW YORK CITY
JULY 13-17, 1969

The magnetism and the grandeur that characterizes New York City will provide a superb setting for AMA's 118th Annual Convention in July. Plan to attend now and look forward to five memorable and stimulating convention days in a city of unlimited excitement.

Continue your postgraduate education with a varied program of • four General Scientific Meetings on Chronic Pulmonary Insufficiency and Problems of Air Pollution, Human Sexuality, Impact of Medical Education on Patient Care, and Physical Fitness and Aging • 23 Section Programs • Color Television • Medical Motion Pictures • and over 700 scientific and industrial exhibits. The nation's outstanding medical authorities will lecture and discuss the significant advances in today's medicine.

In addition the AMA TV network will present more than 40 hours of convention programming.

Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, July 16, 1969. Since space is limited, we suggest you make your reservations before June 30, 1969. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 26, 1969.

NEW YORK CITY, NEW YORK • JULY 13-17, 1969
AMERICAN MEDICAL ASSOCIATION'S 118th ANNUAL CONVENTION

ORGANIZATION SECTION

New Crackerbarrel Session, Panel Discussions To Highlight Annual Meeting Sept. 23-25

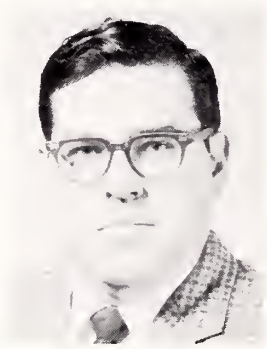
A highlight of the 1969 KMA Annual Meeting will be a Crackerbarrel Session featuring discussions of 20 timely topics on the September 24 scientific program at Louisville's Convention Center. The session will be preceded by a panel discussion of "Obesity".

Guest speakers from across the country will participate in the three-day scientific program which will also feature discussions of "Cancer," "Drugs," "Transplants" and "Atherosclerosis." The guest physicians will also participate in the meetings of 16 specialty groups on September 23 and 25. Other meeting highlights will include the President's Luncheon (see story next page), meetings of the House of Delegates and the Woman's Auxiliary, an Orientation Program for new members, and scientific and technical exhibits.

Participating in the panel discussion of "Obesity," moderated by George W. Pedigo, M.D., Louisville,



Doctor Pearse



Doctor Vastbinder

will be John C. Duffy, M.D., Armonk, N.Y., Earl E. Vastbinder, M.D., Lexington, and John S. Llewellyn, M.D., Louisville. Doctor Duffy, guest of the Kentucky Industrial Medical Association, serves as medical director of the IBM Corporation in Armonk. A graduate of Stanford University medical school, he is a member of the American Academy of Occupational Medicine and the American College of Preventive Medicine.

Doctor Vastbinder, guest of the Kentucky Association of Public Health Physicians, graduated from Ohio State University Medical School in 1961. He is currently an instructor in the department of pediatrics at the University of Kentucky and a member of the Governor's Conference on Drug Abuse.



Doctor Cohen



Doctor Duffy

Participants in the Symposium on Drugs, beginning at 9 a.m. September 24, will include Warren H. Pearse, M.D., Omaha, Neb., who will discuss "Steroid Replacement Therapy," and Sidney Cohen, M.D., Chevy Chase, Md., whose topic will be "The Current Status of Drug Abuse." A guest of the Kentucky Obstetrical and Gynecologic Society, Doctor Pearse is a professor at the University of Nebraska College of Medicine. He is vice-chairman of District VI of the American College of Obstetrics and Gynecology, past secretary-treasurer of that organization, a member of many medical societies and the author of numerous medical publications.

Doctor Cohen, guest of the Kentucky Psychiatric Association, was recently appointed chief of the Center for Studies of Narcotic and Drug Abuse, National Institute of Mental Health. He is editor-in-chief of the *Journal of Psychopharmacology*, a member of the editorial board of *Psychosomatics*, and the author of several books on drug abuse.

St. Joseph Infirmary To Hold Cancer Symposium June 23

St. Joseph Infirmary, Louisville, will hold its second Cancer Symposium June 23 in the Lourdes Hall Demonstration Room, according to Giles Stephens, M.D., Louisville, Cancer Program director. The symposium will be sponsored by the Kentucky Division, American Cancer Society.

Alton Ochsner, M.D., professor of surgery at Tulane University School of Medicine, will be the guest lecturer. He will discuss "What's New in Cancer

of the Lung" and "Gastric Cancer." The one-day program, beginning at 8:30 a.m., will also feature two panel discussions on "The Pulmonary Coin Lesion," and "Gastric Ulcer—Is it Malignant or Benign? Management?"

The symposium has been approved for four prescribed hours by the American Academy of General Practice and all physicians are invited to attend, Doctor Stephens said.

Journalist To Address Physicians At KMA President's Luncheon

M. Stanton Evans, Indianapolis, Ind., editor of the *Indianapolis News,* will discuss "The Future of Freedom" at the President's Luncheon during the Annual Meeting of the Kentucky Medical Association, according to Henry B. Asman, M.D., Louisville, KMA president. The luncheon will be held September 24 in the Flag Room of the Kentucky Hotel.



Mr. Evans

A well-known author and winner of four Freedoms Foundation George Washington medals, Mr. Evans graduated from Yale University in 1955, joined the staff of the *News* as chief editorial writer, and was named editor in 1960.

In addition to his position with the *News,* Mr. Evans is an associate editor and regular columnist for *National Review Magazine.* Some of his publications include "The Liberal Establishment," "Revolt on the Campus," "The Politics of Surrender," "The Lawbreakers," and "The Future of Conservatism."



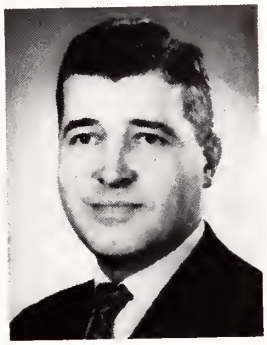
Eugene E. Speer, Jr., (right), administrator for the Louisville Veterans Administration Hospital, accepts the Thirteenth KMA Automotive Safety Award from William K. Keller, M. D., Louisville, on behalf of the hospital.

KAGP Elects Dr. Roach Honors Dr. Seeley

Benjamin F. Roach, M.D., Midway, was named president-elect of the Kentucky Academy of General Practice at its 18th Annual Assembly May 7-9 in Louisville. John G. Rulander, M.D., Louisville, was installed as president, succeeding Elmer G. Prewitt, M.D., Corbin, who presided at the meeting.



Doctor Roach



Doctor Seeley

The Academy named E. C. Seeley, M.D., London, "Citizen-Doctor" of the Year and cited Carroll L. Witten, M.D., Louisville for the best scientific paper of the year. A special award was given to Nicholas Pisacano, M.D., Lexington, for "furthering the teaching of family practice."

Highlights of the three-day session included a luncheon featuring William F. Ekstrom, Ph.D., Louisville, who discussed the timely topic of "Campus Turmoil and Academic Change," scientific presentations by prominent physicians and KAGP members, scientific and technical exhibits and meetings of the Congress of Delegates.

Dr. Roach, a 1943 graduate of the Duke University Medical School, has practiced in Midway since 1949. He is past president of the Blue Grass Chapter of KAGP and past vice-president and vice-speaker of KAGP. He is director of the Kentucky Division, American Cancer Society and a member of KMA's Cancer Coordinating Committee.

Doctor Seeley, a former KAGP president, is a member of the KMA Board of Trustees and an active participant in medical and civic affairs in his community.

KMA Gives Auto Safety Award To Louisville VA Hospital

The Kentucky Medical Association gave its thirteenth Automotive Safety Award to the Louisville Veterans Administration Hospital recently. William K. Keller, M.D., Louisville, representing KMA, presented the award to Eugene E. Speer, Jr., the hospital's administrator.

The award is given to those organizations certifying that their membership wears seat belts at all times. In making the presentation to the VA Hospital, KMA commended it for active concern of its

(Continued on page 446)

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



(Continued from page 443)

employees and their families and for the example set for others.

Members are urged to forward the names of organizations that may qualify for this award to the KMA Headquarters Office.

Dr. Brockman Takes Leave To Head TB Study Group

George F. Brockman, M.D., Greenville, immediate past president of KMA, is taking a two-month leave of absence from his busy private practice to head a committee to study Kentucky's tuberculosis facilities and programs.

Doctor Brockman, who has served two tours of duty with the AMA's Project Viet Nam, commented that he would like to give two months to his state to improve the TB situation. The two major problems facing the study committee are: 1) To determine what must be done if Kentucky is to delete its name from among the annual leaders in TB cases and deaths and 2) To determine the future role of the state's six TB hospitals which have an average occupancy rate of 55 percent.

President of KMA in 1967-68, Doctor Brockman currently serves as chairman of the KMA Comprehensive Health Planning Committee in which role he has been conducting some special studies on tuberculosis in Kentucky.

In his new assignment, he is being furnished an office in the State Capitol in Frankfort for his volunteer work. His appointment was made by state Senator Clyde Middleton, chairman of the Kentucky Health Planning Council. Doctor Brockman is a member of the AMA Plans and Development Committee.

Course in "Ostomy" Care

An intensive one-day course in the care of the "ostomy" patient will be presented on each of three days, June 23, 25 and 27, at the Seelbach Hotel, Louisville.

The course is under the direction of Anita Kotheimer, well-known in this field in the Louisville area, and is sponsored by the United Surgical Company. There will be no registration fee.

Designed especially for nursing personnel entrusted with the care of colostomy and ileostomy patients, this course will also prove interesting and beneficial to physicians. Complete information and pre-registration forms have been sent to hospitals throughout Kentucky.

Kidney Disease Tests Conducted

The nation's first county-wide kidney diseases testing took place March 19 when 2,400 Calloway County school children were screened. The test was sponsored by the Kentucky Kidney Foundation and the Murray Woman's Club.

Mr. Frazier Named Pres.-Elect Of Ky. Hospital Association

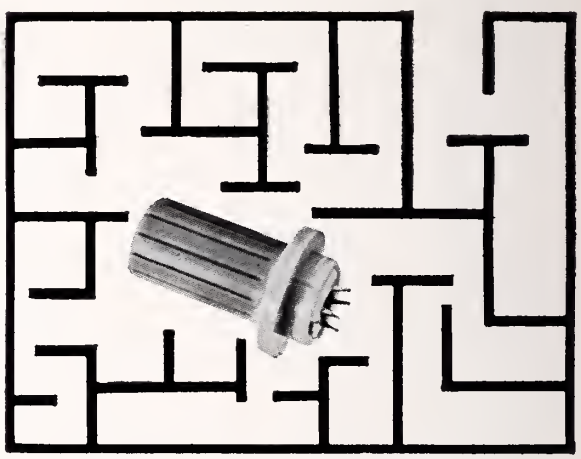
The Kentucky Hospital Association chose Chalmer H. Frazier, Prestonsburg, administrator of Prestonsburg General Hospital since 1956, as its president-elect during the 40th Annual Convention April 21-24 in Louisville. Mr. Frazier succeeds Elmer L. Crozier, Somerset, who was installed as president.



Mr. Frazier

Outstanding hospital authorities participated in discussions of Joint Commission changes, Medicare, Nursing Service Administration, Organized Labor and other topics during the four-day session highlighted by luncheon addresses from Governor Louie B. Nunn and Ralph Nader, author of "Unsafe at Any Speed."

A graduate of Berea College and a former superintendent of Prestonsburg Public Schools, Mr. Frazier has served on numerous KHA committees. He is past president of the Blue Grass Conference, a member of the American Hospital Association and the American College of Hospital Administrators.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

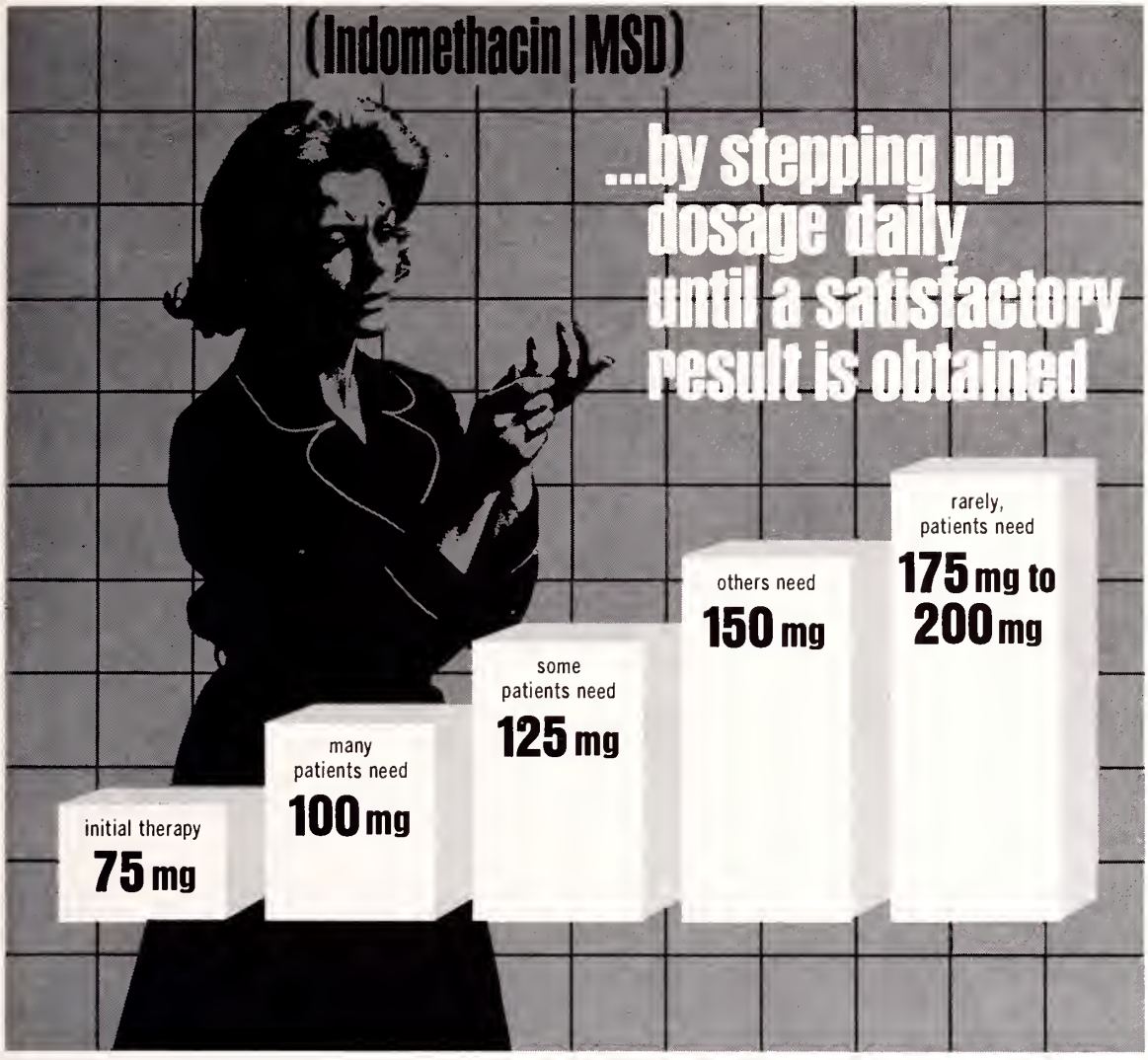
HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

In selected cases of rheumatoid arthritis with acute symptoms

Response to INDOCIN® is often improved...



Many patients with acute rheumatoid arthritis or acute episodes of chronic rheumatoid arthritis can be controlled by increasing the dosage 25 mg *per day* (to the allowable maximum) until the episode subsides; the dosage should then be reduced gradually to maintenance levels. Few require the maximum (175–200 mg).

In the event the patient develops adverse effects, dosage should be reduced to tolerated levels for 2 or 3 days and then gradually increased by 25 mg every few days as tolerated. G.I. effects may be minimized by giving INDOCIN with food, antacids, or immediately after meals.

Now in two strengths
25 mg and 50 mg



Actual Size

INDOCIN®
(Indomethacin | MSD)

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under *Indications*. The drug should not be prescribed for children because safe conditions for use have not been established.

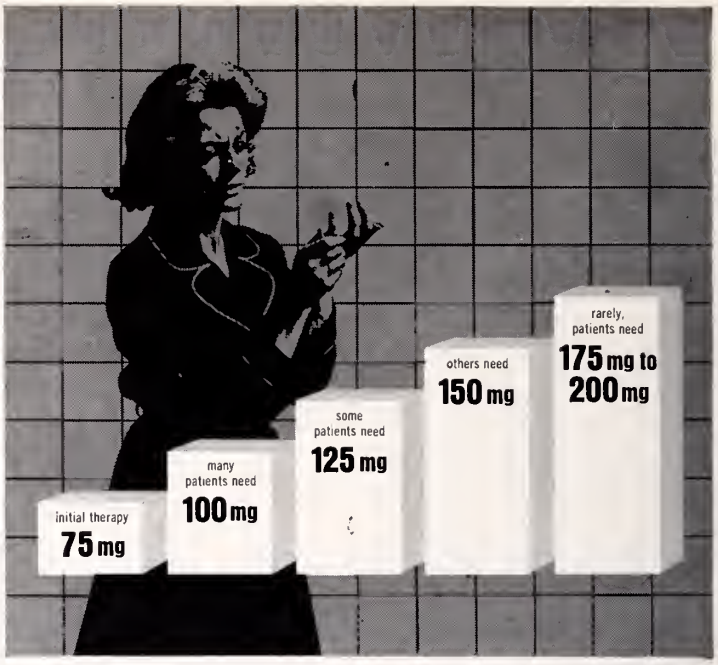
CONTRAINDICATED:

- in aspirin-sensitive asthmatics
- during pregnancy or lactation
- in children
- INDOCIN may mask the signs and symptoms of peptic ulcer and may cause ulceration or irritation of the G.I. tract. Therefore, do not give in active peptic ulcer, gastritis, regional enteritis, ulcerative colitis, and use with caution if there is a history of these disorders.

For additional prescribing information, please see following page.

In selected cases
of rheumatoid arthritis
with acute symptoms

Response to INDOCIN® (Indomethacin | MSD) is often improved by stepping up dosage daily until a satisfactory result is obtained



IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

Indications: For the symptomatic treatment of rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.

Contraindications: INDOCIN may mask the signs and symptoms of peptic ulcer and may itself cause peptic ulceration or irritation of the G.I. tract. For these reasons it should not be given to patients with active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis (use with caution if there is history of these disorders); aspirin-sensitive asthmatics. Safe use during pregnancy or during lactation has not been established. Should not be prescribed for children because safe conditions for use have not been established. In a few cases of severe juvenile rheumatoid arthritis receiving INDOCIN along with other drugs, severe reactions, including fatalities, have been reported.

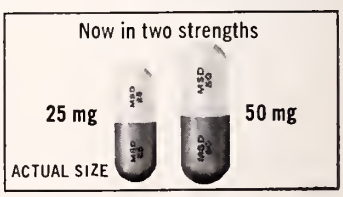
Warnings: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles or machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism since it may aggravate these conditions.

Precautions: Use cautiously in patients with a history of peptic ulcer, gastritis, regional ileitis, or ulcerative colitis because of its potential for causing G.I. bleeding. May cause single or multiple ulceration of the esophagus, stomach, duodenum, or small intestine, and, in a few Instances, severe bleeding and perforation with a few fatalities have been reported. May potentiate the ulcerogenic effect of steroids, salicylates, or phenylbutazone. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; the drug should be discontinued if G.I. bleeding occurs. As a result of obvious or occult G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. In common with other drugs that have anti-inflammatory, analgesic, and antipyretic properties, indomethacin may mask the signs and symptoms of infection; avoid undue delay in initiating appropriate treatment of the infection; use cautiously in patients with existing, but controlled, infections. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.

Adverse Reactions: Starting therapy with low doses, with gradual increases when necessary, will minimize adverse reactions. *Central Nervous System:* Most commonly, headache (usually more severe in morning), dizziness, and lightheadedness; infrequently observed reactions include mental confusion, drowsiness, convulsions, coma, depression, and other psychic disturbances, such as depersonalization; CNS effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. *Gastrointestinal:* Most commonly, nausea, anorexia, vomiting, epigastric distress, abdominal pain, and diarrhea; others that may develop are ulceration, single or multiple, of esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage with a few fatalities having been reported; G.I. bleeding without obvious ulcer formation, increased abdominal pain in patients with preexisting ulcerative colitis; less commonly, stomatitis; gastritis; bleeding from the sigmoid colon, occult in type or from a diverticulum, and perforation of preexisting sigmoid lesions (diverticulum, carcinoma); G.I. reactions not known definitely to be attributable to indomethacin include development of ulcerative colitis and of regional ileitis. *Hepatic:* Rarely, jaundice and hepatitis. *Cardiovascular-Renal:* Infrequently, edema, elevation of blood pressure, and hematuria. *Dermatologic-Hypersensitivity:* Infrequently, pruritus, urticaria, angioneurotic edema, angiitis, skin rashes, loss of hair, and acute respiratory distress including sudden dyspnea and asthma. *Hematologic:* Infrequently, leukopenia, purpura, and thrombocytopenia; rarely, agranulocytosis and bone marrow depression have been reported, but a definite relationship to the drug has not been established; since some patients may manifest anemia secondary to obvious or occult G.I. bleeding, periodic hemoglobin determinations are recommended. *Eye-Ear:* Infrequently, tinnitus, blurred vision, hearing disturbance, and orbital and periorbital pain. *Miscellaneous:* Rarely, vaginal bleeding, hyperglycemia, and glycosuria.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.



MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

AMA House Adopts Resolution On Nursing Education

The House of Delegates of the American Medical Association adopted a resolution on nursing education, particularly related to diploma schools of nursing, at its 1968 meeting in Miami Beach.

Complying with a request from the AMA Committee on Nursing, *The Journal* is printing the resolution in full for the information of KMA members. The resolution follows.

Whereas, The acute shortage of trained nursing personnel throughout the country has posed a serious problem in patient care in our hospitals; and

Whereas, Many nursing schools have been closed in recent years, because hospitals can no longer afford the heavy costs of nursing education, thus compounding the paucity of trained nurses; and

Whereas, At the present time, there is no unified academic program for training nursing personnel; and

Whereas, The licensed practical nurse, the two-year associate degree nurse trained in our community colleges, the three-year diploma nurse trained in our hospital nursing schools, and the four-year baccalaureate university degree nurse are all separate entities and do not complement each other academically; and

Whereas, Recent legislation (H.R. 15757, the Manpower Training Act of 1968) has been passed by Congress, this act providing a subsidy to financially distressed nursing schools, and is obviously intended to alleviate the stress on hospital finances and provide more trained nurses; therefore be it

Resolved, That the American Medical Association urge increased subsidies to hospital nursing schools; and be it further

Resolved, That state and county medical societies be encouraged to study the problems relating to nursing education and to seek at the local level all available sources of financial support for hospital nursing schools; and be it further

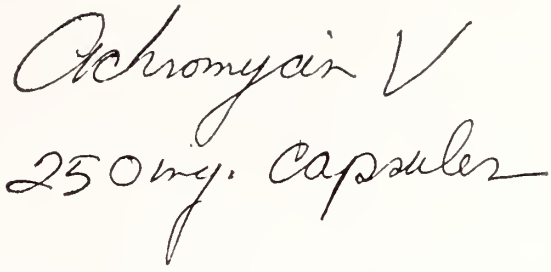
Resolved, That the American Medical Association take appropriate action in consultation with professional nursing associations and the American Hospital Association to encourage increasing enrollment in diploma schools.

DOCTOR SUITE AVAILABLE

Excellent Opportunity
In Highly Populated
Shively Area

Modern, 10-room suite with air conditioning, carpeting, on second floor; elevator, private and public restrooms, Heatherfield Center on Crums Lane. Owner will sacrifice.

Call 447-5483
448-1691



ACHROMYCIN® V
TETRACYCLINE HCl Lederle
4810-9

In Memoriam

GEORGE F. ARCHER, JR., M.D.
Louisville
1911-1969

George F. Archer, Jr., M.D., 58, a Louisville physician since 1937, died April 18 at his home. Death was attributed to a heart attack. A 1937 graduate of the University of Louisville School of Medicine, Doctor Archer was a professor of medicine at that institution.

MARINUS H. PULSKAMP, M.D.
Louisville
1892-1969

Marinus H. Pulskamp, M.D., 76, a retired proctologist, died May 6 at Twinbrook Nursing Home. A 1918 graduate of the St. Louis University School of Medicine, Doctor Pulskamp was a member of the Southern Medical and Southeastern Surgical Societies and a fellow of the American College of Surgeons.

(Continued on page 455)



A little Hygroton

chlorthalidone



can work a long diuretic day

all the way from one daily tablet to the next to help control edema and hypertension

Its prolonged action usually provides smooth, sustained diuretic effectiveness; real one-a-day dosage, right from the start; convenience and economy.

Hygroton, chlorthalidone, can cause side effects. And it's contra-indicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the passibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated patassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and passibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against passible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in pastsympathectomy patients and in patients receiving ganglionic blocking agents, other patent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or patassium depletion may occur. If patassium depletion should occur during therapy, the drug should be discontinued and patassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps; orthostatic hypatension, which may be patentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impatence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reparted with this class of compaunds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY. 6674

–The lowest priced tetracycline–nystatin combination available–



★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

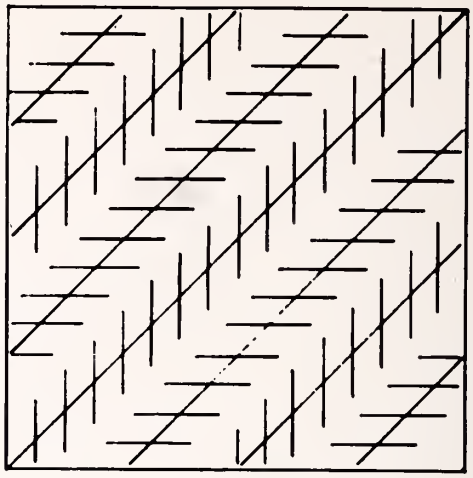
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201

(Continued from page 449)

THOMAS S. WALLACE, SR., M.D.
Louisville
1881-1969

Thomas S. Wallace, Sr., M.D., 87, a retired Louisville physician, died April 23 at Anne Lynne Manor Nursing Home. He had practiced in Louisville for 45 years until his retirement. Doctor Wallace was a 1905 graduate of the University of Louisville School of Medicine.

KMA Committee Reports

Plans and Development Committee

George A. Sehlinger, M.D., Louisville, Chairman

KMA Headquarters Office **April 10, 1969**

The new Plans and Development Committee completed its second meeting within two months with the purpose of organizing the committee in its final form and planning its future activities.

The committee members reviewed numerous items referred to them for consideration in the area of administrative matters, the organizational structure of KMA and the changes to the Constitution and Bylaws. It was generally agreed that background material would be secured and the committee would meet again in the fall to propose such recommendations as may be indicated.

Memorials Commission

Eugene H. Conner, M.D., Louisville, Chairman

KMA Headquarters Office **April 17, 1969**

The Memorials Commission accepted three additional gifts to the Memorial Museum and made plans to present an exhibit at the KMA Annual Meeting in September.

The Commission is attempting to obtain a complete set of the transactions of the Kentucky Medical Association, and a list of those known to have been published was reviewed and recorded in the KMA files. In other action, it was decided to attempt to change the name of the street on which the KMA Headquarters is located.

Health Exam Survey To Visit Ky.

Breathitt, Lee, Morgan, Owsley and Wolfe Counties will be visited by the Health Examination Survey of the U.S. Public Health Service from May 29 to July 24. The Survey will examine some 200 youths from ages 12 to 17 for the purpose of collecting data on growth and development.

The survey is the Third Cycle of the program which was conducted in 1962 and again in 1965. Statistical information will be sought; the survey is not a screening procedure and referrals for diagnosis will not be made. Reports of findings will be sent to an individual's physician, however, upon the request of his parents.

NEWS ITEMS

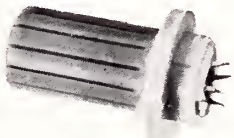
David W. Dorman, M.D., an ear, nose and throat specialist, is practicing in association with Alex M. Forrester, M.D., in Louisville. A 1959 graduate of Cornell University Medical College, Doctor Dorman completed his internship in Buffalo, N.Y. and his residency training at the University of Louisville in 1968.

William N. Postell, M.D., a cardiologist, is associated with R. L. Rainey, M.D. at Louisville General Hospital. Doctor Postell graduated from the Medical College of Georgia in 1961 and completed his internship there in 1966. He recently completed two years of practice with the U.S. Public Health Service.

Larry A. Raymond, M.D., an ophthalmologist, is associated with John J. Ryan, M.D. in Louisville. A 1962 graduate of the University of Louisville School of Medicine, Doctor Raymond completed his residency training at the University of California Medical Center in 1968.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665.....President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660....Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123.....Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661.....Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211.....Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282.....Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552..Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340.....1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255.....1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362..1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231.....1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406.....1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751.....1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155....1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698.....1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357.....1969

Buyers Guide

JUNE BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Medical Association 441
Blue Cross-Blue Shield 391
Bristol Laboratories 457
Burroughs Wellcome 437
Business & Professional Adjustment Service, Inc. 400
Doctor Suite 449
Geigy Pharmaceuticals 430-431, 4S0-4S2
General Leasing Corporation 397
Highland Hospital 4S4
Hynson, Westcott & Dunning 38S
Lederle Laboratories 387, 400, 40S, 446, 449, 453, 4S5
Lilly, Eli & Company 408
Medical Protective Company 4S3
Merck, Sharp & Dohme 447-448
Parke, Davis Company 403, 423
Pitman-Moore Company 406-407
Riker Laboratories 396-397
Robins, A. H. Company 440
Roche Laboratories 398-399, 438-439, 4S8
Rorer, Wm. H. Company 389
Searle, G.D. & Company 424-42S
Smith, Kline & French 384
Southern Optical Company 4S4
Stuart Company 404
Wallace Pharmaceuticals 434-436
Warner-Chilcott 393-394
Winthrop Laboratories 426
Wyeth Laboratories 444-44S

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

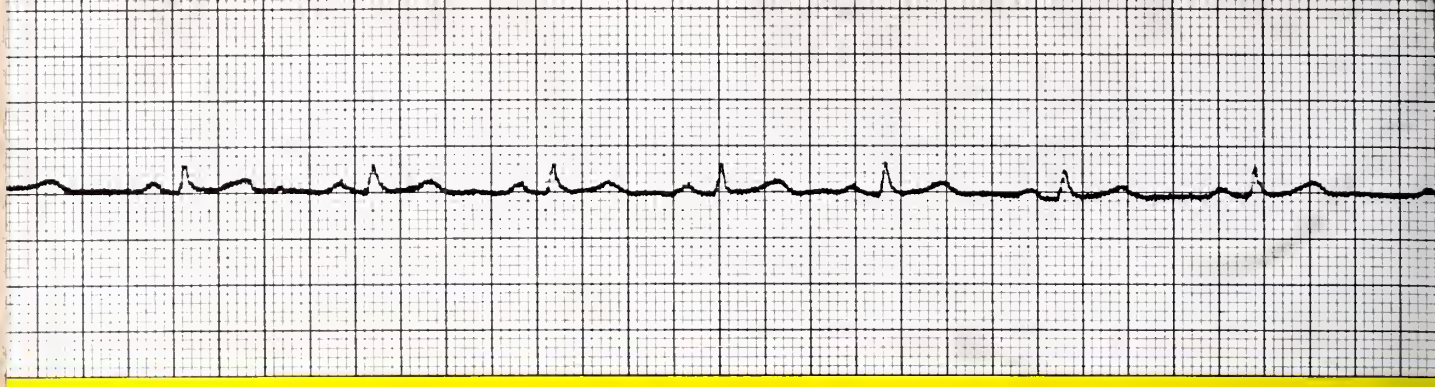
Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens... and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®
(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.
For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

VOLUME 67 JULY 1969 NUMBER 7

The Journal of The KENTUCKY Medical Association



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUL 17

In This Issue

Treatment of Childhood Asthma
N. I. Handelman, M.D. and M. S. Nall, M.D. 491

Tetanus in the Bluegrass Area
Affonso R. Meira, M.D., Ibrahim Ildirim, M.D. and Michael L. Furcolow, M.D. 496

Whiplash Abdominal Injury
Romeo S. Berardi, M.D. 501

Special Article

OEO Programs in Kentucky: A Progress Report 504

Complete Contents on page 462

KMA 1969 ANNUAL MEETING
September 23-25
Convention Center, Louisville



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Cancurrently with MAO inhibitors, in patients hypersensitive ta this drug; in emationally unstable potients susceptible to drug abuse.

Warning: Although generally sofer than the amphetamines, use with great caution in patients with severe hypertension ar severe cardiovascular disease. Do not use during first trimester of pregnancy unless patential benefits autweigh potential risks.

Adverse Reactions: Rarely severe enough ta require discontinuation af therapy, unpleasant symptoms with diethylpropian hydrochloride have been reported to occur in relatively law incidence.

As is charocteristic of sympathomimetic agents, it may accosianally cause *CNS effects* such as insomnia, nervausness, dizziness, onxiety, and jitteriness. In contrast, CNS depressian has been reported. In a few epileptics an increose in convulsive episodes has been reported.

Sympathomimetic *cordiavascular effects* reported include ones such as tachycardia, precardial poin, orrhythmia, palpitation, and increased blaad pressure. One published repart described T-wove chonges in the ECG of a healthy yaung male after ingestian af diethylprapian hydrochloride; this was an isolated experience, which has nat been reported by others.

Allergic phenamena reported include such canditians as rash, urticaria, ecchymasis, and erythema. *Gastrointestinal effects* such as diarrhea, canstipatian, nausea, vamiting, and obdominal discamfort hove been reported.

Specific reports on the hematopoietic system include twa each af bone morrow depression, ogronulocytasis, ond leukapenia.

A voriety af miscellaneous adverse reactions have been reported by physicians. These include camplaints such as dry mauth, headache, dyspnea, menstrual upset, hoir loss, muscle pain, decreosed libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 o.m.); TEPANIL: One 25 mg. tablet three times doily, one haur before meals. If desired, an odditional toblet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous releose form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-919A U.S. PATENT NO. 3,001,910 9/69

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Volume 67 • July 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Peggy Roberts

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussions
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1972
Richard R. Crutcher, M.D.
Chrisman S. Jackson, M.D.
E. Truman Mays, M.D.
Joseph Parker, Jr., M.D.
Elmer G. Prewitt, M.D.
Carl E. Rutledge, Jr., M.D.
Winston Rutledge, M.D.
A. Franklin White, M.D.

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D.
Roy A. Martin, M.D.
Charles R. Perry, M.D.
David C. Shipp, M.D.
John H. Willard, M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Treatment of Childhood Asthma
N. I. Handelman, M.D. and M. S. Nall, M.D. 491

Tetanus in the Bluegrass Area
Affonso R. Meira, M.D., Ibrahim Ildirim, M.D. and Michael L. Furcolow, M.D. 496

Whiplash Abdominal Injury
Romeo S. Berardi, M.D. 501

SPECIAL ARTICLES

OEO Programs in Kentucky: A Progress Report 504

EDITORIALS

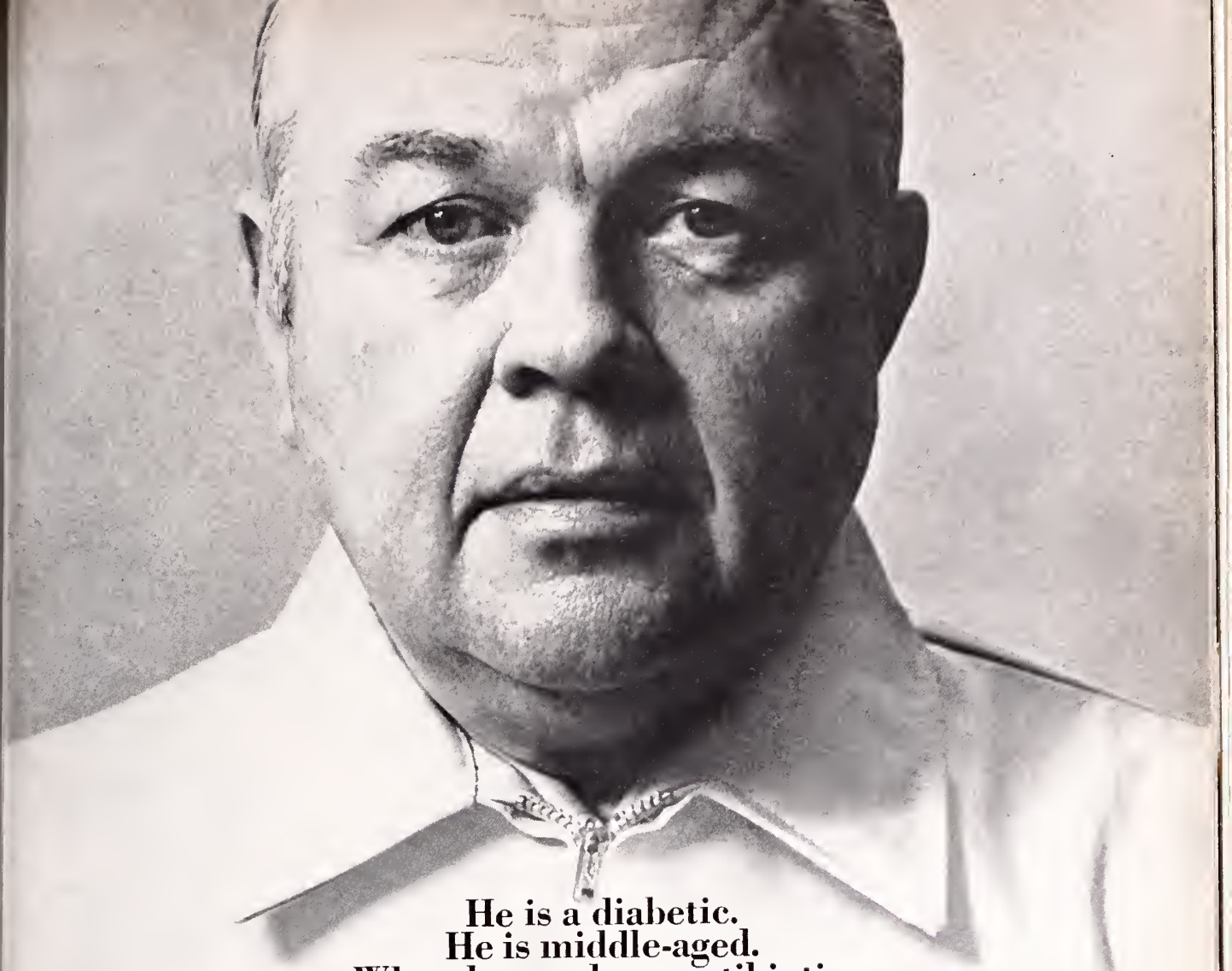
Medicaid Today
Sam A. Overstreet, M.D. 513

ORGANIZATION

Prominent National Authorities To Join Kentucky Physicians In Timely Discussions at Annual Meeting, Sept. 23-25 516
Scientific Program Outline Released for Annual Mtg. 517
Kentucky Surgeons Elect Dr. Clardy, Dr. Ray 525
All 15 KMA Trustee Districts Hold Meetings in 1968-1969 525
KMA Washington Dinner Hosts All Ky.'s U.S. Congressmen 526
KEMPAC Invites U.S. Congressmen To Speak at Annual Seminar ..526
Eighteen-Member Ky. Delegation Attends AMA/AMPAC Seminar ..526
One-Millionth Member Enrolls in Kentucky Blue Shield 526
KSAMA Holds Seventh Convention May 16-18 at Elizabethtown 527
Scholarship Fund Grants Loans to 35 Medical Students 527

REGULAR FEATURES

President's Page 464
Public Health Page 465
In The Books 468
Insurance Page 473
Maternal Mortality Page 478
Postgraduate Opportunities ..486



He is a diabetic.
He is middle-aged.
When he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300 b.i.d.

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



Medical Review Activities

IN THESE days of such rapid change in the practice of medicine or the delivery of health care, there is one area that is growing more and more important each day—if we hope to preserve the free enterprise "fee-for-service" we have so long cherished.

I refer, of course, to the area of "medical review" or, if you will, "quality control" of medical practice.

In spite of the implications of headlines and news stories regarding the size of physicians' fees, knowledgeable people realize that the financial problems of federal and state health programs lie, not in the fee the physician charges for an individual service but (1) in patient over-utilization of services which have been offered to him free-of-charge, and (2) in physician over-utilization, chiefly in the form of unnecessary medical services.

It is distasteful to the physician to have to refuse to the patient the services he feels have been promised to him; it is disgraceful for the physician to perform, and charge for, any service he knows is not medically justifiable. Any way we look at it, the burden falls upon the physician—and the profession must accept it!

We must develop mechanisms of "peer review" in Kentucky to make certain that the *quality* of medical practice in our state is of the highest caliber. We have "peer review" in the matter of fees; our frame of reference in this instance, however, is not the justification of the size of a fee, but the justification of the number of office visits, the number of hospital days, or the drugs prescribed in a given illness of an individual patient. Did this URI require $40 worth of prescription drugs? Did the control and stabilization of that diabetic demand daily office visits and blood sugars for 20 days? Was seven days hospitalization, with complete x-ray studies of the spine and intestinal tract, really necessary in the patient with "low-back" pain? If these things were necessary—fine! And our records should justify our actions. If not, then we are guilty of abusing a third-party, whether it be the government, the Blues, or any commercial insurance company.

In some areas of the country the mechanisms for "medical review" have been developed, and are functioning with varying degrees of success. It is incumbent upon us to proceed in that direction without delay. The alternative, I fear, is the forfeiture of our "birth-right" for, if we don't do it, *somebody* is going to do it for us—and to us!

Henry B. Asman

PUBLIC HEALTH PAGE

Basic Concepts of Rubella Eradication†

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

RUBELLA, also known as German measles, was first described by Home in 1759. It was disregarded as a mild contagious disease until 1941 when Gregg, an Australian opthalmologist, associated severe congenital defects with rubella during pregnancy. Since then the relationship between maternal rubella and congenital anomalies such as cataracts, deafness, mental retardation and various cardiac abnormalities has been clearly established.

In 1962 researchers at the Harvard School of Public Health and the Walter Reed Army Medical Center, working independently, succeeded in isolating rubella virus. In 1966 the first major field trials of live attenuated rubella virus vaccine were conducted.

At present three attenuated rubella live virus vaccines are under active consideration for licensure in the United States. The Merck, Sharp and Dohme strain (HPV77 DE5) was prepared by passing rubella virus 77 times in primary African green monkey kidney cell culture and five times in duck embryo cell culture. Phillips Laboratories developed a similar strain (HPV77 DK12) passed 77 times in primary African green monkey kidney cell culture and 12 times in dog kidney cell culture. Smith, Kline and French has developed the Cendehill strain by passing wild rubella virus 51 times in primary rabbit kidney cell culture. All three strains appear to be safe and effective for immunization of prepubertal children over one year of age. Immunization of adult women with HPV77 vaccines, however, has resulted in the frequent occurrence of a severe, transient polyarthralgia often associated with fever and rash. These reactions have been less frequent and less severe with the Cendehill strain.

The advent of safe and effective rubella virus vaccines and the threat of a major rubella epidemic in the early 1970's have stimulated the federal government to set aside 9.6 million dollars to launch a nationwide rubella eradication program similar in scope to the polio and measles campaigns of the past decade.

Theory and Practice of Rubella Immunization

Prevention of rubella during the first trimester of pregnancy is the primary justification for a rubella eradication program. However, because of the undetermined hazard of rubella vaccine virus in pregnancy, it should not be given to pregnant women or those who may become pregnant within two months following immunization.

Epidemiologic study has shown that rubella in the United States is primarily a disease of young school children with epidemic transmission often occurring within the classroom environment. Transmission to susceptible pregnant women has usually been the result of exposure to infected children.

All factors considered, the only practical way to prevent rubella in the United States during pregnancy would be to eliminate the major reservoir of infection by properly immunizing the large majority of susceptible prepubertal children over one year of age. This undertaking will necessitate the immunization of boys as well as girls. Since clinical history is an unreliable means of determining naturally acquired rubella immunity, and since serologic studies are available only on a very limited basis, all children within the specified age group should be immunized without regard to sex or clinical history of rubella-like illness.

Because of the theoretical risk of congenital malformation due to rubella vaccine, the Public Health Service Advisory Committee on Immunization Practices in collaboration with the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics has recommended the following procedure whenever immunization of a woman of childbearing age is contemplated:[1]

1. The woman should be tested for susceptibility to rubella by the HI test. (The only reliable evidence of immunity is a positive serologic test. Because of technical difficulties involved with this particular serologic procedure, results should be accepted only from laboratories of recognized competency that regularly perform these tests. The laboratory asked to carry out HI tests for rubella only infrequently should refer diagnostic materials to the State Health Department or other competent reference laboratory.)[1, 2]

(Continued on page 467)

† *This article was prepared by The Office of Communicable Diseases, Division of Epidemiology, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky 40601*

NORGESIC

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesic



For musculo-skeletal pain,

try Norgesic first . . .
8 of 10 patients probably won't need anything stronger

Norgesic offers predictable relief in approximately 80% of patients with painful musculo-skeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. Norgesic works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try Norgesic first...eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use ot this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering Norgesic to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

Sponsors of Riker Service—
the complimentary classified service for physicians.

(Continued from page 465)

2. If immune, the woman should be assured that vaccination is unnecessary.

3. If susceptible, the woman may be vaccinated if she is not pregnant and steps are taken to ensure that she will not become pregnant within two months following immunization. This will require conscientious use of a medically acceptable means of pregnancy prevention. Adult women should also be warned of the transient arthralgia, fever and rash which frequently follow administration of rubella vaccine in this age group.

Obviously, rubella immunization should not be conducted on a routine basis in adolescent and adult women. Each woman must be considered individually.

Even in the absence of rubella, up to three percent of all births may present with significant congenital malformations. Thus, when immunizing against rubella, care should be taken not to give the impression that the vaccine will prevent all types of congenital malformation.

The rubella eradication campaign to be launched shortly after vaccine licensure will present several problems unprecedented in previous disease eradication programs. The necessity of immunizing pre-adolescent boys to prevent rubella transmission will raise the question of immunizing one person (a boy) to protect another (a woman of child-bearing age). The public must be educated to the fact that this new "measles vaccine" is different from the other "measles vaccine." Appropriate management of women of child-bearing age in respect to rubella immunization may well require additional high-quality laboratory services to screen large numbers of women for rubella HI antibody. Although no official statements have been issued, it is anticipated that rubella vaccine will be more expensive than rubeola vaccine both to public and private providers of health services.

As in the past, the Kentucky State Department of Health will continue to make available HI serologic study and immune serum globulin for women exposed to rubella during the first trimester of pregnancy. At present the Division of Laboratory Services does not have the personnel or financial resources to offer HI rubella serology as a routine screening procedure for all women of child-bearing age. The Office of Communicable Diseases (phone 502-564-4935) will serve as a clearing house for current information regarding rubella immunization, administer the health department aspects of Kentucky's rubella immunization campaign and provide vaccine and technical assistance to local health units.

The stage has been set by the close collaboration of the Public Health Service and the American Academy of Pediatrics.[1] Once rubella vaccine has been licensed it will be the joint responsibility of practicing physicians and public health personnel at the state and local levels to see that the goal of rubella eradication is achieved.

References

1. Public Health Service Advisory Committee on Immunization Practices: Prelicensing Statement on Rubella Virus Vaccine; MMWR *18*:5 April 12, 1969.

2. Public Health Service Medical Laboratory Services Advisory Committee: Serologic Testing for Rubella—A Warning; MMWR April 12, 1969.



QUESTIONS AND ANSWERS ON CONTACT LENS PRACTICE: by Jack Hartstein, M.D.; Published by The C. V. Mosby Company, St. Louis, 1968; 200 Pages; Price $10.75.

This book contains a detailed presentation of the techniques of fitting contact lenses. Although the level of presentation is basic, the experienced contact lens fitter may gain some helpful hints from the material presented.

The method of presentation uses a number of rhetorical questions each followed by several paragraphs of explanation. This type of presentation lends itself to good indexing and to covering a large number of the details which are so necessary in successful contact lens fitting.

Slit lamp examination of the cornea is taken up in minute detail as are conditions such as keratoconus. Specific directions for use of the keratometer are included. Corneal and scleral contact lenses are discussed concisely. Modification of technique for unusual cases is well covered. The techniques and equipment for inspection and in-office modification of lenses are well described.

The book contains an appendix with useful and necessary conversion tables. The index is sufficient to make the book a very useful reference manual.

This is an excellent book for the beginner in contact lens work and also would serve as a reference for the details of day to day routine problems of contact lens fitting.

THEODORE LAWWILL, M.D.

SYMPOSIUM ON SURGICAL AND MEDICAL MANAGEMENT OF CONGENITAL ANOMALIES OF THE EYE—TRANSACTIONS OF THE NEW ORLEANS ACADEMY OF OPHTHALMOLOGY: Published by the C. B. Mosby Company, St. Louis, 1968; 500 Pages; 283 Figures; 8 Color Plates; Price $29.50.

This book contains the symposium presented at the New Orleans Academy of Ophthalmology midwinter convention, February 12-17, 1967. It is an excellent discussion of inheritance and hereditary anomalies of the eye. The title is somewhat misleading because the book is almost entirely on diagnosis and heredity with very little surgical or medical management. The contributors are outstanding men in the field of congenital anomalies—Beard, Falls, Franceschetti, Francois, Goodman, Krill and Scheie.

The several chapters are written in somewhat different style and illustrations are of varying quality. In general the book is very readable and is an excellent source for review of the diagnosis and methods of investigation of hereditary ocular defects. The subject of family counselling in cases of hereditary defects is handled with tact. Surgical procedures for congenital cataract, glaucoma, and lid anomalies are the only procedures covered in any detail.

The physiological techniques of diagnosis including ERG, EOG, dark adaptation, and color vision testing are discussed in a clinical manner.

This is an excellent book for a physician or ophthalmologist who is interested in reviewing the subject of hereditary defects specifically as they relate to the eye. While the subject could never be completed in this size of book, the more important syndromes and isolated defects are covered in a readable and understandable manner.

This book is highly recommended as both a review textbook and an office reference.

THEODORE LAWWILL, M.D.

ALCOHOL AND THE IMPAIRED DRIVER: Committee on Medicolegal Problems, Russell S. Fisher, M.D., Chairman; Published by the American Medical Association, Chicago, Illinois, 1968; 234 Pages; Price $1.50.

This beautifully produced treatise on the problem of alcohol and driving, with 229 references, covers the subject in a most comprehensive manner. Coming as it does from the Committee on Medicolegal Problems of the American Medical Association, this book could easily become a standard reference.

The chapter headings give an insight into facets of this medically important subject. They range from alcohol and traffic safety through the effects of the drug on the human system on to, and including, medicolegal aspects with which the physician must be concerned.

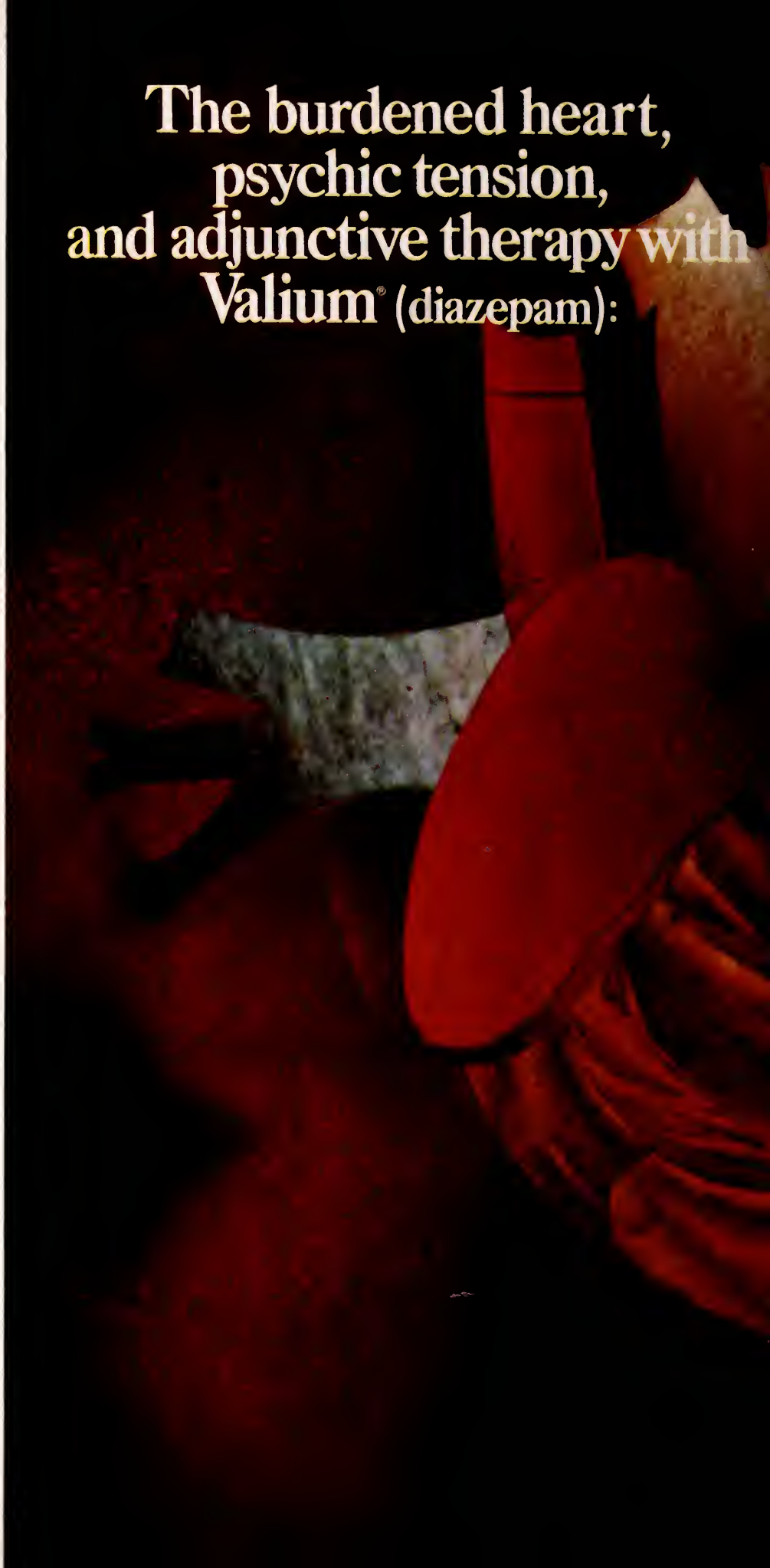
The wide outline of information, the low price, its clarity of expression, and excellent illustrations all combine to recommend this book to all physicians. The question of alcohol and the impaired driver should be of interest to all of us.

WILLIAM K. KELLER, M.D.



The burdened heart...

The burdened heart, psychic tension, and adjunctive therapy with Valium® (diazepam):



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Artist's conception schematically showing varying ischemic ventricular muscle tissue.

To help lift psychic tension from the already burdened heart

When the cardiac patient shows signs of panic-like reactions following initial diagnosis—a daily regimen of 10-mg Valium (diazepam) tablets *t.i.d.* or *q.i.d.* can help control *severe* psychic tension, anxiety, apprehension and agitation. For *less severe* emotional stress, the 5-mg tablet usually provides the desired calming effect.

When the cardiac patient's outlook impedes convalescence—Valium, as it relieves psychic tension, can help the patient regain a realistic perspective... help him deal more rationally with convalescence by countering excessively anxious attitudes towards the future.

When the cardiac patient can't adjust emotionally to post-recovery limitations—Valium, through its prompt and pronounced calming action on psychic tension, may help avoid exacerbation or aggravation of cardiac symptoms.

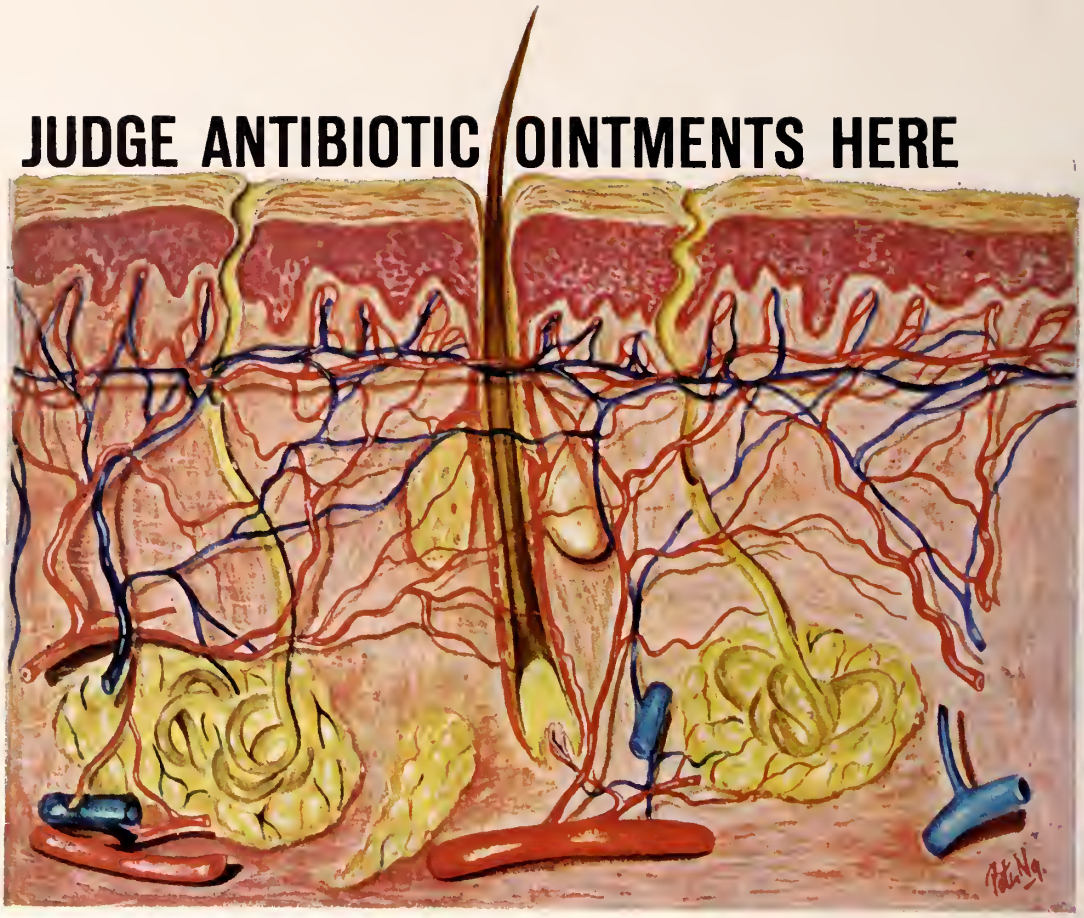
On proper maintenance dosage, Valium seldom dulls the senses or interferes with functioning.

Should anxiety-induced insomnia be a problem— an *h.s.* dose added to the *t.i.d.* schedule usually helps permit a night of restful sleep.

Valium®
(diazepam)

2-mg, 5-mg and 10-mg tablets
t.i.d.* and *h.s.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



THE INSURANCE PAGE



Usual and Customary

IT HAS become quite obvious that pre-payment organizations cannot be competitive in the marketplace unless they are able to provide contracts that provide paid-in-full benefits for covered services. Today's public indicates a willingness to purchase contracts based on physicians' usual and customary charges when there is predictability of cost and when the patient is guaranteed the right to choose his own physician with some assurance that the physician's fee for covered services will be paid in full.

The Kentucky Medical Association recognized this trend when it originally urged Blue Shield to develop programs that would provide payment based on physicians' usual and customary charges and reaffirmed support of this principle at the meeting of the 1968 House of Delegates. The resolution urged the development of these types of programs by Blue Shield and third parties. It also provided for the Kentucky Medical Association to play a very integral part in the development, through the appointment of a special KMA Claims Review Committee representative of all major specialty groups. The committee was to work with Blue Shield and third parties in developing the mechanism and establishing the necessary guidelines for the implementation and administration of the program. However, Blue Shield is the only organization that has offered organized medicine the opportunity to involve itself in the development and implementation of its Usual and Customary Program. Blue Shield and the Kentucky Medical Association have been working together toward the establishment of county medical society review committees to review and recommend a reasonable allowance on cases that cannot be processed routinely. This mechanism as called for in the resolution guarantees the individual physician, the county medical society and the state association that physicians will be making decisions at all levels.

Blue Shield has implemented the Usual and Customary Program based on the direction of the House of Delegates and much effort has been made to communicate information to physicians about the resolution, its intent and the approved guidelines for its administration. However, several questions have been raised as to the paid-in-full connotation and the individual rights of a physician to accept or not to accept such policy. These questions were presented through the proper channels and the KMA Board of Trustees referred the points in question to the Kentucky Medical Association's Advisory Committee to Blue Shield and charged them with the responsibility to review and recommend clarification of the intent of the program.

After careful review of all the information, the KMA Advisory Committee to Blue Shield recommended that Usual and Customary and the paid-in-full concept be one and the same and the individual rights of physicians to participate be protected by signifying their support of the Usual and Customary concept and by signing an agreement to that effect.

It further recommended that the KMA Board of Trustees working in cooperation with Blue Shield institute an immediate continuing multi-phasic program to assist the profession and the public in the explanation and implementation of the Usual and Customary Program and that the Board of Trustees urge Blue Shield's staff to continue marketing the Usual and Customary Program under the present guidelines while working toward obtaining individual participating physician agreements.

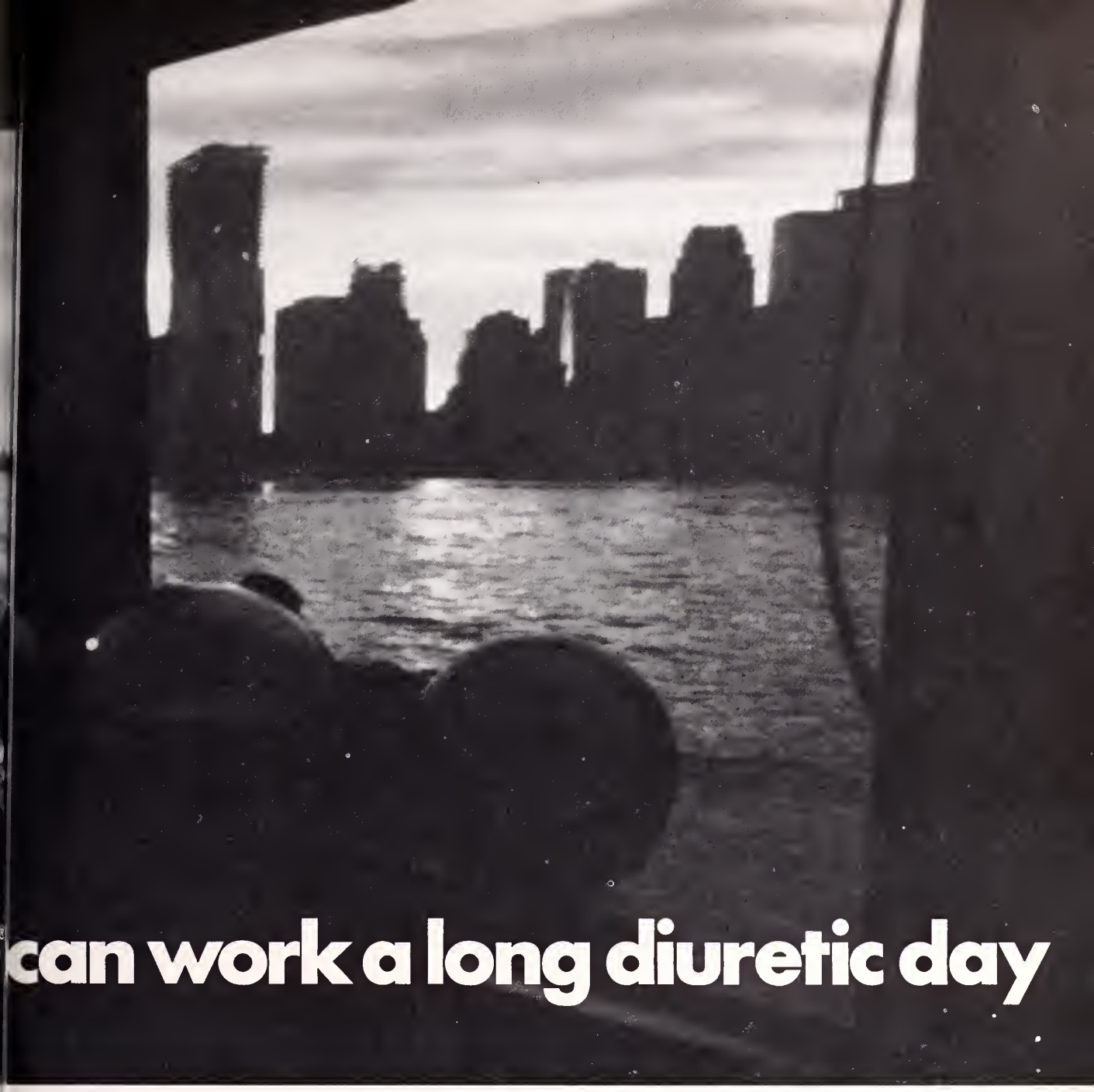
Experience to date indicated Blue Shield's program has been working and working very well. Statistically, under the Usual, Customary and Reasonable concept and using the mechanism as approved by the KMA Claims Review Committee, Blue Shield has processed 41,876 claims resulting in only .38%, or less than ½ of 1%, being referred to review committees.

The support of individual physicians is essential for the success of the Usual and Customary paid-in-full concept. It behooves each physician to give this matter positive consideration because it is a program that is most beneficial to the physician, to the patient and to the voluntary prepayment program in Kentucky.



A little Hygroton

chlorthalidone



all the way from one daily tablet to the next to help control edema and hypertension

Its prolonged action usually provides smooth, sustained diuretic effectiveness; real one-a-day dosage, right from the start; convenience and economy.

Hygroton, chlorthalidone, can cause side effects. And it's contra-indicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY. 6674



50%

WHY PAY IT???

You don't have to with our new BUSINESS & PROFESSIONAL PRE-COLLECTION PLAN. All monies come direct to you.

GUARANTEED TO WORK

Write for full details, P.O. Box 172, Harlan, Kentucky 40831

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 14-64. This 15 year old, white, single, gravida 1, para 0, was seen in the emergency room of the hospital September 23, 1967. She had been well until three days before when she began to have a cough. In the 24 hours preceding admission she became nauseated, developed a fever and began to have convulsive episodes. She became unconscious. There was no history of previous convulsive episodes nor had she been on any medication. When seen on admission she was completely unresponsive and had tonic type convulsions every three minutes involving the right side of her body. She also had some nystagmus. The patient's parents were unaware that she was pregnant. There was no history of accidental trauma to the head, diabetes or kidney disease.

Physical examination revealed T 103.4, blood pressure 100/70. She had some signs of conjunctivitis and periorbital edema, her optic discs, however, were sharp and clear. There was no hemorrhage and the pupils reacted to light and were equal. There were many rhonchi and rales scattered throughout the chest; no dullness was noted. The heart sounds were clear, pulse 96, no murmurs were heard and the rhythm was regular. The abdomen was enlarged to the level of the umbilicus; the fetal heart was heard. Vaginal examination revealed some yellowish-green discharge; however, the cervix was closed, long and thick.

Examination of the extremities revealed no Babinski reflexes. There was intermittent tonic rigidity of both right arm and right leg. There were no reflexes present on the right side. A BUN and blood sugar were obtained and were normal. She could not be aroused. An intravenous infusion of D-5-W was started. Seven and one half grams Amytal to control the convulsions was given. In addition she received Amytal IM and Dilantin IM. A spinal tap was obtained; the fluid was clear with very low opening pressure. The fluid contained two red cells, one lymphocyte; total protein was 92 percent. Her serology was negative.

A medical and neurosurgical consultant saw the patient and suggested she be treated with large doses of IV antibiotics and IV fluids. X-rays revealed areas of infiltrate in the lung compatable with a diagnosis of broncho-pneumonia. She was digitalized, and oxygen was started. An EKG was obtained and was normal.

The patient never regained consciousness. As the Jacksonian type convulsive seizures were controlled the Amytal and Dilantin were reduced. Labor began spontaneously with delivery of a viable one pound 13 ounce female in her room on September 26. The infant expired several hours after delivery of the respiratory distress syndrome.

The patient stopped breathing on the 27th and artificial respiration failed.

Blood culture returned after death grew staphylococcus aureus. An autopsy was obtained which showed a mycotic aneurysm and clot involving the basal arteries and the middle cerebral artery on the left with infarction of the entire left half of the brain. She also had staphylococcal myocarditis and endocarditis, acute interstitial pneumonia and focal hepatitis. It was considered that her death was unrelated to the pregnancy. This started as a respiratory infection, followed by a staph endocarditis, septicemia with emboli of the basilar and middle cerebral artery. The terminal event was the apnea secondary to the degenerative changes within the brain.

Comment

The committee classified this as an indirect obstetrical death without apparent preventable factors. The possibility of a criminal attempt to interrupt the pregnancy was considered. It is presented in order to emphasize certain socio-economic problems that can influence the outcome of a pregnancy.

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

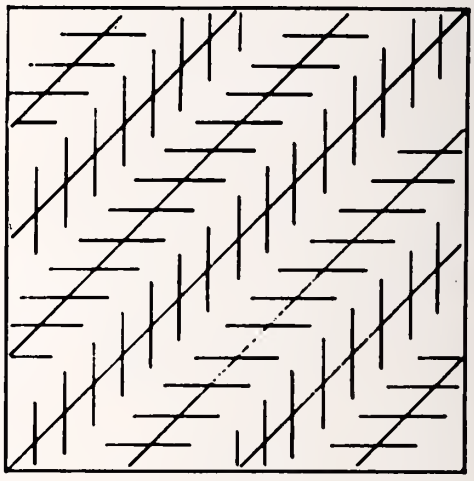
Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M may be better to start on and easier to stay on.

introducing new

GELUSIL®-M*

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient.



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens...and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®
(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.
For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Medical Economics says:
GENERAL LEASING'S PLAN IS
"The Winning Way"
TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE.
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ Leasing better than buying
- ★ No capital investment
- ★ Dependable car at all times
- ★ Certain tax advantages
- ★ Call us for particulars

LEASE
Medical or Surgical
EQUIPMENT

- ★ A plan for young doctors
- ★ Medical and Surgical equipment
- ★ Complete office furnishings
- ★ Enlarging facilities
- ★ Call us for full details

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

IN KENTUCKY

JULY

16-17 KAGP Seminar, Jenny Wiley State Park, Prestonsburg

AUGUST

24 Symposium on the Common Fungus Infections for the Clinician, University of Kentucky College of Medicine and KAGP, Imperial House, Lexington

SEPTEMBER

23-25 KMA ANNUAL MEETING. Convention Center, Louisville

OCTOBER

26-30 Medical Library Association, Annual Meeting, Louisville

NOVEMBER

6-7 Third Annual Newborn Symposium, Department of Pediatrics, University of Louisville School of Medicine, Louisville

13-14 Recent Developments in the Surgical Care of Trauma Program, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

JULY

18-19 Annual Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

29-Aug. 1 Developmental Pediatrics Postgraduate Course, American Academy of Pediatrics, University of Texas Medical Branch, Galveston, Tex.

AUGUST

10-15 American Congress of Rehabilitation Medicine Annual Session, Palmer House, Chicago, Ill.

17-22 American Congress for Physical Medicine and Rehabilitation, Chicago, Ill.

18-21 American Hospital Association Annual Meeting, Chicago, Ill.

SEPTEMBER

4-6 American Association of Obstetricians and Gynecologists, Hot Springs, Va.

15-16 Congress on Occupational Health, American Medical Association, St. Louis, Mo.

24-26 Cleveland Course in Pulmonary Diseases, St. Luke's Hospital, Cleveland, Ohio.

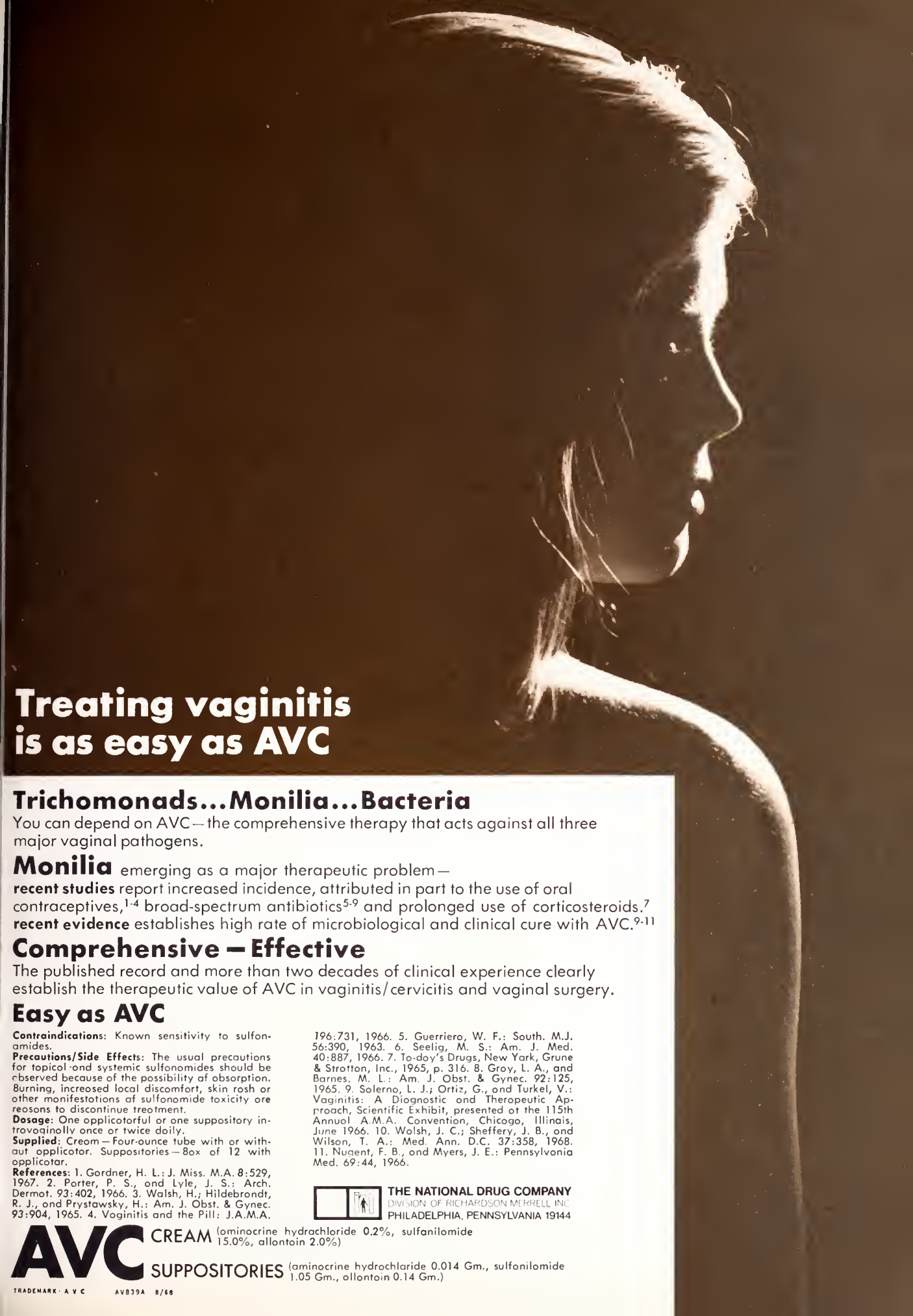
26-Oct. 3 American Academy of General Practice, Philadelphia, Pa.

OCTOBER

18-23 American Academy of Pediatrics, 38th Annual Meeting, Palmer House, Chicago, Ill.

NOVEMBER

10-13 Southern Medical Association, 63rd Annual Meeting, Atlanta, Ga.



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Side Effects: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Groy, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminocrine hydrachloride 0.2%, sulfanilomide 15.0%, allontoin 2.0%)

SUPPOSITORIES (aminocrine hydrochloride 0.014 Gm., sulfonilomide 1.05 Gm., allontoin 0.14 Gm.)

TRADEMARK · A V C

AV839A 8/68

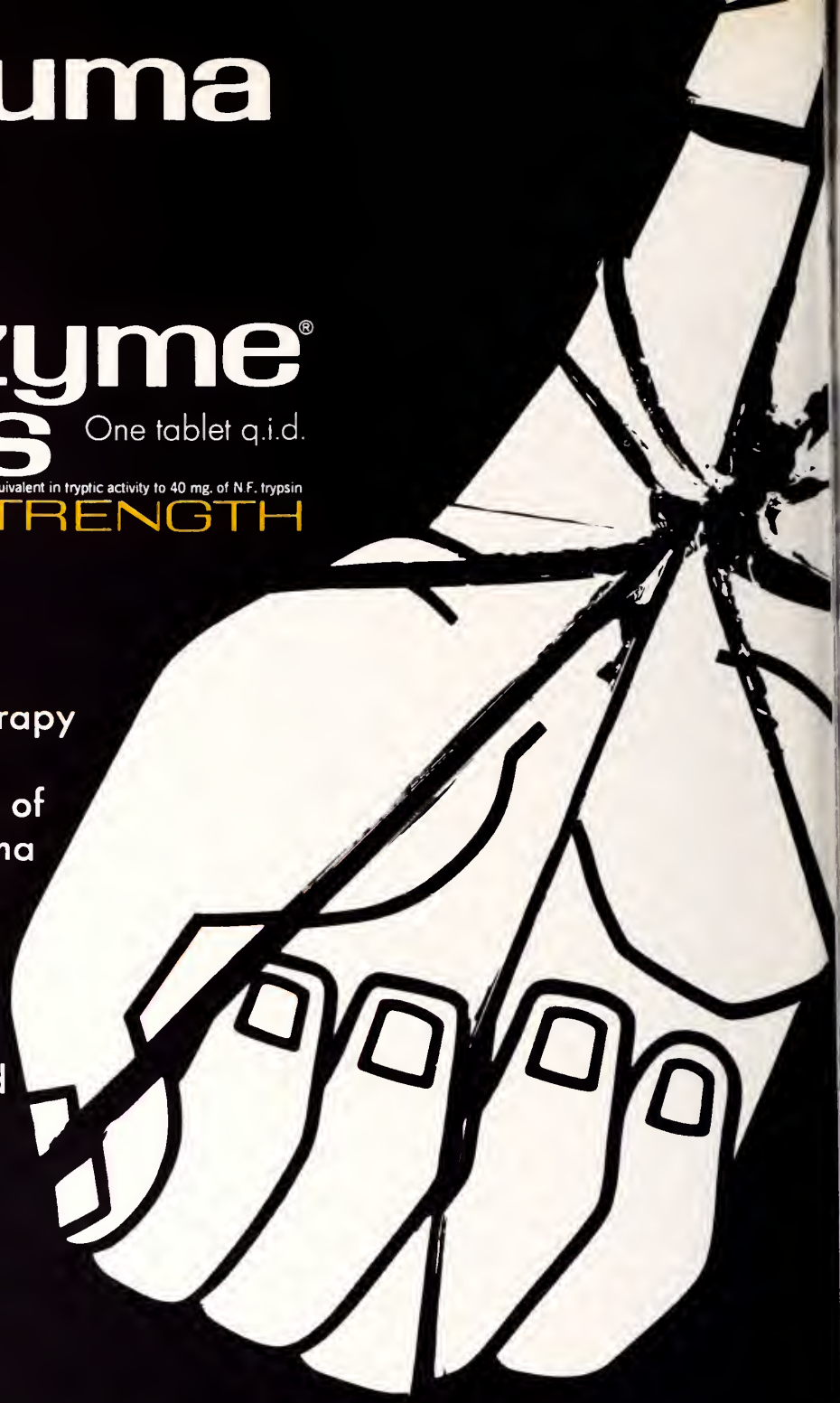
in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

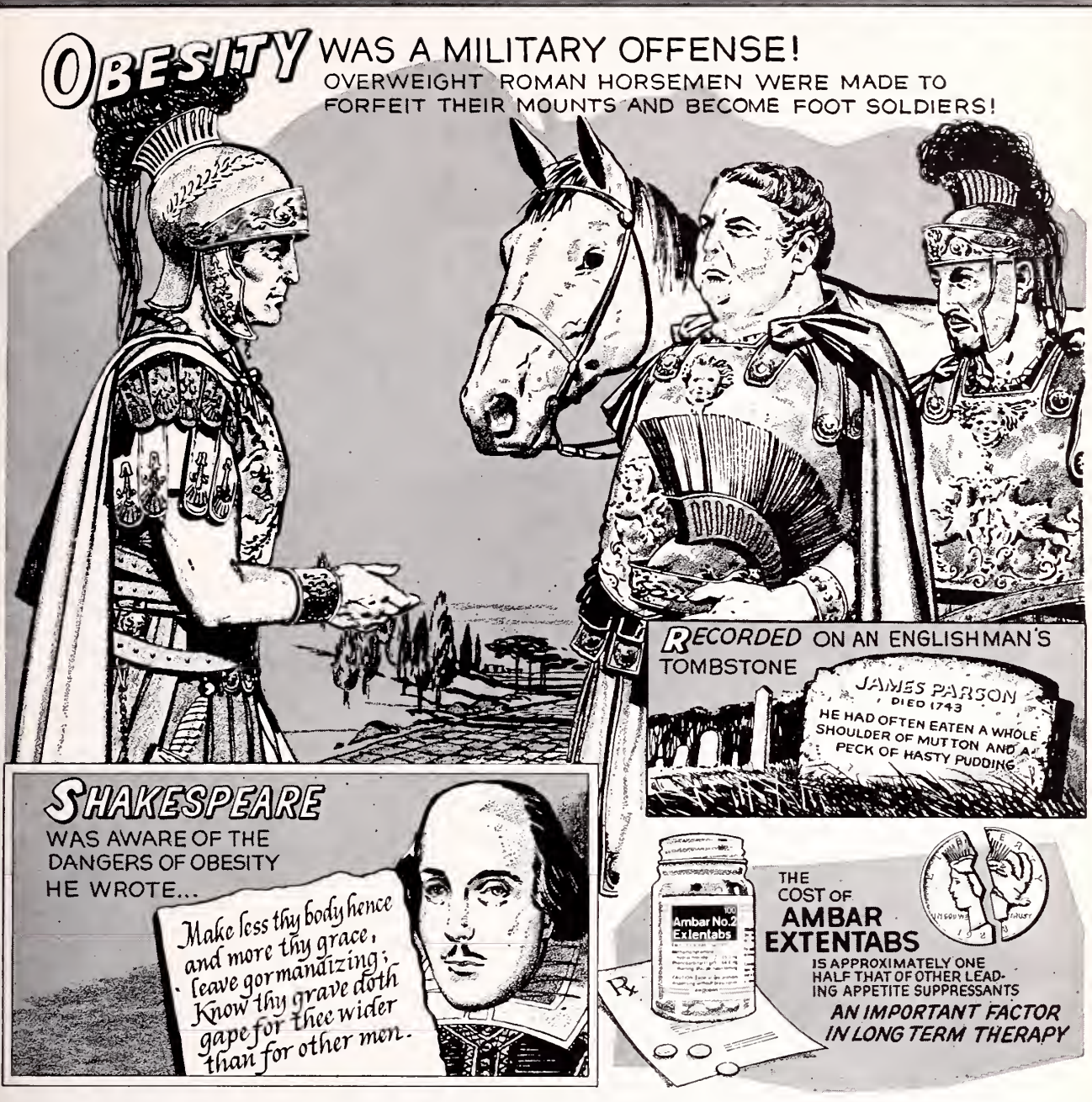
Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS


Lilly
H06
Lilly
H06
Lilly
H06
Lilly
H06
Lilly
H06
Lilly
H06
Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 JULY 1969 No. 7

Treatment of Childhood Asthma

N. I. HANDELMAN, M.D.* AND M.S. NALL, M.D.**

Louisville, Kentucky

A plan of management for the symptomatic therapy of childhood asthma in its various degrees of severity is discussed.

THE problem of asthma in children is becoming more and more evident to the practicing physician. Precise statistics concerning the percentage of children with asthma are difficult to define. However, in a random survey of 2,000 children in the Chicago area in 1967, 4.9 percent had asthma diagnosed by a physician.[1] Dees reported that the incidence of asthma found in various pediatric practices with the diagnosis made by examination was 6.6 to 9 percent.[2] The incidence may even be higher since asthma often masquerades as other conditions such as bronchiolitis, bronchitis and recurrent pneumonitis.

In the United States during 1964 there were 1.21 million cases of asthma among children six to 16 years of age.[3] Death from asthma in a child has been considered rare but it can be a lethal disease. It still ranks among the 60 leading causes of death in this country in children under 15 years of age.[4]

Significant advances have been made during the past decade in the clinical management of this common disease. In this article we will present a simplified protocol for the symptomatic therapy of asthma in its various degrees of severity. This paper stems from an outline prepared for the staff of the pediatric department of the University of Louisville School of Medicine.

It is important to understand the pathophysiology of asthma in order to treat the patients effectively. This is a complex problem not fully understood but the initial event triggering extrinsic asthma is thought to be reintroduction of a specific antigen and its interaction with antibody on or near the surface of sensitized cells. This causes the liberation of several chemical mediators with powerful pharmacological actions producing increased capillary permeability, mucous gland hyper-secretion and smooth muscle contraction. These chemical mediators are thought to include histamine, slow reacting substance, plasma kinins, acetylcholine and serotonin.

Recently, a hypothesis has been put forward that an imbalance of the autonomic nervous system plays an important role in asthma and other allergic disorders.[5] There are two types of adrenergic effector systems: the alpha and beta. Bronchodilation is mediated by beta receptors. Animal studies have shown that chemical blockade of the beta receptors can be accomplished by administration of certain drugs which results in heightened sensitivity to histamine. This simulates the exaggerated responsiveness of the human asthmatic to histamine.[6]

Keeping in mind the essential pathological changes in the bronchi and bronchioles—

*Associate clinical professor of pediatrics and director of pediatric allergy, University of Louisville School of Medicine.
**Fellow, pediatric allergy, University of Louisville School of Medicine

spasm, edema and hypersecretion of mucous—the specific medical regimen will be discussed.

Home Care

One of the cardinal features of the medical regimen is hydration in an effort to remove the thick viscid bronchial secretions. Water vapor is an effective method of liquifying secretions and is probably an effective expectorant. Asthmatics are prone to dehydration due to poor fluid intake, tachypnea and frequent vomiting. It is important to impress on the parents to push oral fluids when their child begins to wheeze.

In recent years, iodide salts have been used as expectorants on the basis of some evidence that they stimulate the production and thus liquification of bronchial mucous. Contradictory results regarding the effectiveness of iodotherapy have been reported. Falliers studied 52 asthmatic children and found that doses of 300 mg of K1 three times a day influenced the course of asthma favorably and maintenance steroids could be greatly reduced in a significant number of the children during treatment.[7] However, Forbes administered potassium iodide to patients with chronic lung disease and then measured the viscosity of the daily output of sputum. He found no evidence that these drugs effectively lowered sputum viscosity.[8] Also, thyroid adenomas have been reported as a side effect of oral iodide therapy.[9] If the physician feels iodide therapy is of value, it is important to keep close observation on the status of the thyroid.

The bronchodilators play an important role in the management of asthma at home. The commercial preparations consist of either xanthine alone or xanthine in combination with a sympathomimetic, barbiturate, and sometimes an expectorant. Xanthines are weakly basic alkaloids. Caffeine, theophylline, and theobromine are three closely related xanthines which occur in plants widely distributed throughout the world. From earliest times man has made beverages from aqueous extracts of these plants, for example, coffee, tea, cocoa and cola drinks. *Theophylline is the xanthine used in asthma therapy.*[10] It acts directly on the smooth muscle of the bronchi causing relaxation. The dosage of these drugs should be determined by the theophylline content and is *4-5 mg/Kg three times a day.* Theophylline intoxication continues to occur despite repeated warnings in the literature. *The therapeutic and toxic levels in the serum are very close.* Yunginger found that excellent relief was usually observed at serum Theophylline concentrations of more than 0.5 mg % and objective signs of untoward reactions appeared in excess of 0.7 mg %.[11]

Theophylline is a powerful diuretic so fluids must be given to avoid dehydration. White reviewed 24 cases of aminophylline intoxication including four deaths. The common feature in all cases was some sign of CNS irritability probably because of decreased cerebral blood flow. In the majority of cases vomiting occurred which is due to direct gastric irritation. At autopsy petechia of the gastric mucosa were found and in some cases esophageal perforation.[12] A common error is to administer the drug to a child already receiving it. When a child is admitted to the hospital, the parents should be questioned closely about how much medication the child has had at home. In many cases of severe toxicity, the theophylline has been given by rectal suppositories. Absorption by this route is very erratic.[13-16] However, Yunginger has shown that when theophylline is administered rectally in the form of a retention enema the absorption is regular.[11] Theophylline is of value in the treatment of asthma but it is of utmost importance that the proper dose be adhered to which is 4-5 mg/Kg by any of the three usual routes every eight hours (P.O., IV or rectally).

Antibiotics should be used whenever there is evidence of infection from positive chest X-ray findings and less specifically fever, leukocytosis or purulent sputum and rhinorrhea. Richards reviewed 24 asthmatic deaths and found that pneumonitis was the most frequent post mortem finding.[17] If possible, bacterial cultures should always be taken first so that antibiotic therapy can be guided by the sensitivity tests.

Nebulization therapy using Isuprel 1:400 or 1:800 diluted with normal saline is frequently used in severe cases. Some clinicians add an enzyme or detergent to the Isuprel solution. There are several brands of nebulizers but the DeVilbiss glass nebulizer #40 attached to a small air compressor or to a bicycle pump has proven to be very effective. Postural drainage and forced coughing should follow nebulization treatment.

It may be necessary to use steroids but only after the other forms of treatments have been fully tried. The patient's tuberculin skin test should be checked and his urine tested for sugar before steroids are given. The role of steroids in the treatment of asthma is controversial. The Drug Committee of the Research Council of the American Academy of Allergy studied 122 patients who had been on steroids for six months or longer. The most frequent side effects reported were weight gain, moon facies and ecchymosis. There was no need to stop treatment in any of the patients because of side effects.[18] A serious objection to the use of steroids in children is their growth inhibiting effects. However, most children with severe asthma are small because of their disease. Smith studied a group of intractable asthmatic children and found that 43 percent were below the tenth percentile before steroids were started. He felt that the beneficial effects of steroid therapy outweighed the inhibitory effect on growth.[19] For patients who have to be on long-term steroid therapy there is evidence that a single dose should be administered on alternate days, preferably in the morning. This mode of therapy reduces side effects and causes less suppression of the endogenous pituitary-adrenal axis.[20] If steroids are used the physician is obligated to follow the patient and give cortisone at the time of any severe stress such as surgery during the year following termination of the steroids.

Emergency Room Treatment

When the asthmatic child is seen in the office or emergency room in respiratory distress, the drug of choice is adrenalin. Adrenalin 1:1000 aqueous solution may be given subcutaneously and repeated one time in 20-30 minutes if needed. Dosage is 0.01 ml/Kg with a top dose of 0.5 ml. The majority of the patients will respond to the first injection. If the patient is significantly improved after adrenalin, susphrine (1:200 aqueous suspension of epinephrine in 10 percent glycerine, 2 percent sodium Theoglycolate and 0.5 percent chlorobutenal) can be given subcutaneously and will last up to 12 hours. The dosage is 0.005 ml/Kg. It is important to use the correct dosage because both arterial and venous pressures are increased by the alpha adrenergic stimulation of epinephrine. Overdose may send the patient into pulmonary edema because of elevated pulmonary capillary filtration pressure. Bronkephrine HCl (Ethylnorephrine HCl) which has less side effects may be used in place of adrenalin. Also, nebulization using the Bennett (or other IPPB) apparatus if one is available may be helpful.

If the patient does not respond to adrenalin, it may be due to the presence of mucosal congestion, retained bronchial secretions and the patient may be acidotic. In this case the diagnosis of status asthmaticus is made and the patient hospitalized. Just taking the child out of stressful and perhaps antigen laden home environment may of itself produce beneficial effects.

Hospital Care

On admission the patient should be placed in an oxygen tent with high humidity in an effort to liquify his bronchial secretions. Forty percent ambient oxygen should be given if the patient is cyanotic or the Pa O_2 indicates it. It is important to add the high humidity because oxygen alone tends to have a drying effect. The newer ultrasonic nebulizers are more effective in that they produce water particles of a small enough diameter to penetrate deeper into the tracheobronchial tree.

Any patient in status who is admitted to the hospital should be hydrated with intravenous fluids. After questioning about previous medications, aminophylline may be given 4 mg/Kg over 20-30 minutes every six hours through the IV. If steroids are indicated, hydrocortisone can be injected into the IV tubing every six hours up to 12 mg/Kg per day. However, it will take approximately six hours before there is any clinical improvement due to the steroids.

When the pH of the serum is between 7.25 and normal, the aqueous adrenalin can be given every four hours or susphrine can be given every 12 hours. Instead of adrenalin, Bennett therapy with Isuprel 1:400 10 cc H_2O pressure and 40 percent oxygen may give the patient a great deal of relief.

If the patient is restless or agitated, light sedation may be used. Chloral hydrate is probably the drug of choice.[21] The dosage is 20 mg/Kg, but sedation must be used with caution because these symptoms may be due

TABLE I

CRITERIA FOR DIAGNOSIS OF RESPIRATORY FAILURE IN CHILDREN WITH STATUS ASTHMATICUS

1. Severe Respiratory retractions.
2. Barely audible (or absent) wheezing and breath saunds.
3. Minimal tharacic mavements with hyperinflation.
4. Depressed level af cansciausness and respanse to painful stimulation.
5. Cyanasis in 40% ambient oxygen.
6. $PaCO_2$ 50-65 mgm mercury ar higher.

Three criteria necessary far diagnasis

to severe hypoxia or aminophylline intoxication. *Morphine is contraindicated in asthma.*

If the patient is not responding to medication, it is important to follow his pH and blood gases closely often every hour. The only way to ascertain the presence of mild respiratory failure is to measure arterial blood levels of oxygen and PCO_2. As the patient's airway obstruction progresses respiratory acidosis results from retention of CO_2. Also, in the absence of adequate tissue perfusion with oxygen, lactic acid is formed and the patient develops a superimposed metabolic acidosis. *When the pH is 7.25 or less, sodium bicarbonate, 1.5 mEq/Kg, can be given over a period of 15 to 30 minutes intravenously.* The amount of sodium bicarbonate to be given can also be calculated from the base deficit.[22] Acidosis decreases pulmonary perfusion in patients with bronchoconstrictive disease and correction of acidosis may lead to prompt return of bronchomotor reactivity to epinephrine. Of course, the most effective way to treat respiratory acidosis is to mechanically ventilate the patient.

When the patients in status fail to respond to intensive medical therapy, the last resort is controlled respiration by mechanical means. However, this procedure should not be delayed until coma or apnea occurs because of the irreversible damage produced by severe hypoxia. The clinical diagnosis of respiratory failure can be made when the patient satisfies three of the criteria listed in Table I. The blood gases are the most objective and useful criteria.[23] When the diagnosis is made the patient is placed under the supervision of the anesthesia department and is placed on muscle relaxants and mechanically ventilated. With close cooperation between anesthesiologist, pediatrician, allergist and nursing personnel there is no reason a child with status asthmaticus should die from respiratory failure. Reisman reported treating patients in status on the respirator for periods up to seven days with good results.[24]

The treatment program as discussed is outlined (see chart). It is hoped that this chart will be of value to the clinician.

HOME CARE

I. **EXPECTORANTS**
- A. SSKI-1 drop/year to 15 drops t.i.d. in liquids
- B. Organidin (iodinated glycerol) - Dosage same as SSKI

II. **BRONCHODILATORS**

The dosage should be determined by Theophylline content and is 4-5 mgm/Kg (up to 300 mgm) every 6-8 hours
- A. Xanthine - Oral preparation (example)
 1. Quibron - Theophylline 10 mgm/cc
- B. Combination of a Xanthine, Sympathomimetic and Barbiturate (example)
 1. Tedral Suspension - 1 teaspoon contains: Theophylline 65 mgm, Ephedrine HCl 12 mgm., Phenobarbital 4 mgm.

III. **ANTIBIOTICS - IF INDICATED**

IV. **NEBULIZATION THERAPY**

Using Isuprel 1:400 or 1:800 with normal saline.
- A. Compressors
 1. DeVilbiss - No. 501 or similar unit.
 2. Bicycle Pump
 3. Bennett apparatus
- B. Connector - This includes tubing
- C. Nebulizer - as an example DeVilbiss No. 40

V. **PHYSICAL THERAPY**

VI. **STEROIDS - IF ALL ELSE FAILS**

OUTPATIENT (EMERGENCY ROOM)

I. **LAB TESTS AND X-RAYS - AS INDICATED**

II. **SYMPATHOMIMETICS**

Use A, B or C - If patient responds may continue with D.
- A. Epinephrine 1:1000 aqueous solution. Dosage is 0.01 ml/Kg and may be repeated one or two times every 20-30 minutes.
- B. Bronkephrine HCl - Dosage is 0.02 ml/Kg.
- C. Nebulization - using Bennett Apparatus
- D. Susphrine - Dosage is 0.005 ml/Kg.

III. **HOSPITALIZE - IF PATIENT DOES NOT RESPOND**

HOSPITAL CARE

I. **FLUIDS ADMINISTERED INTRAVENOUSLY**
- A. 5% Dextrose in water in 0.2% sodium chloride solution or hydrating solution. Add KCl as indicated.
- B. Aminophylline 4 mgm/Kg every 6 hours given over a period of 15-30 minutes.
- C. Hydrocortisone 100 mgm every 6 hours (up to 12 mgm/Kg/day) injected into IV tubing
- D. Sodium Bicarbonate 1.5 mEq/Kg given over a period of 15-30 minutes - if indicated.

II. **NEBULIZATION THERAPY**

III. **CONTINUE SYMPATHOMIMETICS IF PATIENT RESPONDING**
- A. Epinephrine (1:1000) subcutaneously 0.01 ml/Kg every 4 hours or
- B. Susphrine 0.005 ml/Kg every 12 hours

IV. **OXYGEN TENT WITH 40% O_2 AND HUMIDITY**

V. **RELIEVE GASTRIC DISTENTION BY ASPIRATION**

VI. **BLOOD (ARTERIAL) pH, PO_2 and P CO_2 REPEATED EVERY HOUR IF NECESSARY**

VII. **LIGHT SEDATION WITH CHLORAL HYDRATE - 10-20 mg/Kg.**

VIII. **ANTIBIOTICS AS INDICATED**

Conclusion

The incidence of death associated with asthma is certainly greater in adults than in children. However, it is of the utmost importance to treat the childhood asthmatic in order to decrease the incidence of asthma in adulthood and thus reduce the morbidity and mortality rates from this disease. Johnstone has shown in a double blind study that intensive treatment of asthma in childhood makes a significant difference in the natural course of this disease. In addition to the symptomatic therapy as discussed in this article the total management of the childhood asthmatic should include an adequate allergy survey, environmental control, hyposensitization therapy and dietary management if indicated.[25]

Bibliography

1. Arbeiter, H.L.: How Prevalent is Allergy Among United States School Children, *Clin. Pediat.* 6:140, 1967.
2. Dees, S.C.: Development and Course of Asthma in Children, *Am. J. Dis. Child.* 93:228, 1957.
3. Sherman, W.B.: *Hypersensitivity,* Philadelphia, W.B. Saunders Co., pp. 226, 1968.
4. *Vital Statistics of the United States*: Vol. II, Part A, 1-12, 1965.
5. Szentivanyi, A., and Fishel, C.W.: Effect of Bacterial Products on Responses to the Allergic Mediators, in Samter, N., ed.: *Immunological Diseases,* Boston, Little, Brown and Co. pp. 226-241, 1965.
6. Middleton, E.: The Anatomical and Biochemical Basis of Bronchial Obstruction in Asthma, *Ann. Intern. Med.,* 1963: 695, 1965.
7. Fallers, C.J., McCann, W.P., Chai, H., Ellis, E.F., and Vazdi, N.: Controlled Study of Iodiotherapy for Childhood Asthma, *J. Allerg.* 38:183, 1966.
8. Forbes, J., and Wise, L.: Expectorants and Sputum Viscosity. *Lancet* 2:767, 1957.
9. Segal, S.: The Asthma-Suppressive Action of Potassium Iodide, *J. Allerg.* 35:252, 1964.
10. Goodman, L.S., and Gilman, A.: *The Pharmacological Basis of Therapeutics* New York, Macmillan Co., p. 358, 1965.
11. Yunginger, J.W., Shigeta, M., Smith, L., Green, M., and Keitel, H.G.: Serum Theophylline Levels and Control of Asthma Following Rectal Theophylline, *Ann. Allerg.* 24:469, 1966.
12. White, B.H., and Daeschner, C.W.: Aminophylline Poisoning in Children, *J. Pediat.* 49:262, 1956.
13. Ridolfo, A.S., and Kehlstaadt, P.K.G.: A Simplified Method for Rectal Instillation of Theophylline, *Amer. J. Med. Sci.* 237:585,1959.
14. Waxler, S.H., and Schack, J.A.: Administration of Aminophylline (Theophylline Ethylenediamine), *J.A.M.A.* 143: 736, 1956.
15. Brodwall, E.K.: The Resorption of Theophylline (Theophylline Ethylenediamine) Blood Concentrations After Intravenous, Peroral, Rectal and Intramuscular Administration, *Acta Med. Scand.* 146:123, 1953.
16. Truitt, E.B., Jr., McKusick, V.A. and Krantz, J.C.: Theophylline Blood Levels After Oral, Rectal and Intravenous Administration and Correlation with Diuretic Action, *J. Pharmacol. and Exper. Therap.* 100:309, 1950.
17. Richards, W., and Patrick, J.R.: Deaths from Asthma in Children. *Am. J. Dis. Child.* 110:23, 1965.
18. Drug Committee of the Research Council of the American Academy of Allergy: Side Effects of Prolonged Corticosteroid Treatment in Patients with Asthma, *J. Allerg.* 40:88, 1967.
19. Smith, J.M.: Long Term Steroid Treatment in Asthmatic Children, *Ann. Allerg.* 23:492, 1965.
20. Ackerman, G.L., and Nolan, C.M.: Adrenocortical Responsiveness After Alternate-Day Corticosteroid Therapy: *New Eng. J. Med.* 278:405, 1968.
21. Mansmann, H.C.: Management of the Child with Bronchial Asthma, *Pediat. Clin. N. Amer.* 15:357, 1968.
22. Wood, D.W., Downes, J.J., and Lecks, H.I.: The Management of Respiratory Failure in Childhood Status Asthmaticus. Experience with 30 Episodes and Evolution of a Technique, *J. Allerg.* 42:261, 1968.
23. Downes, J.J., and Wood, D.W.: Mechanical Ventilation in the Management of Status Asthmaticus in Children. In Eckenhoff, J.E. ed: *Science and Practice in Anesthesia,* Philadelphia, J.B. Lippincott Co., p. 141, 1965.
24. Reisman, R.E., Friedman, I., and Arbesman, C.E.: Severe Status Asthmaticus: Prolonged Treatment with Assisted Ventilation, *J. Allerg.* 41:37, 1968.
25. Johnstone, D.E., and Dutton, A.: The Value of Hyposensitization Therapy for Bronchial Asthma in Children - A 14 year Study, *Pediatrics* 42:793, 1968.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Tetanus in the Bluegrass Area
A Report of Recorded Cases in the Hospitals of Lexington, Kentucky from 1950 to 1968†

AFFONSO R. MEIRA, M.D.*, IBRAHIM ILDIRIM, M.D.**
AND MICHAEL L. FURCOLOW, M.D.***

Lexington, Kentucky

Forty cases of tetanus were found recorded in Lexington's hospitals. The results show that efforts have to be pushed to reach universal tetanus immunization and that research in improved methods of treatment should be encouraged.

TETANUS is not only one of the greatest public health problems in most developing countries of the world, but it continues to be present in developed countries in spite of efforts to eradicate it. There is no single area in the world free of this infection.[1]

The United States is not an exception. Periodic reviews of the tetanus status made in this country show that this disease has not been eradicated at all. In 1939 Moore and Singleton[2] presented mortality data for the period from 1923 to 1932. A report from 1951 to 1955 was done by Axnick and Alexander.[3] In 1964 Heath, Zusman, and Sherman[4] presented a report reviewing the tetanus situation in the United States from 1950 to 1960. The incidence and control of tetanus in New York state, excluding New York City, was reported in 1966 by Albrecht.[5]

One other review of the status of tetanus as a health problem in the United States was based on the analysis of Tetanus Surveillance Forms, submitted to the National Communicable Disease Center (NCDC) for the years 1965 and 1966.[6] This study represented 95 percent of all cases of tetanus reported in the United States for that period, and showed that in spite of the well-known effectiveness of prophylatic immunization and the widespread availability of tetanus toxoid, tetanus remained a disease with an impressive mortality. In 1969 similar data were published by La Force, Young, and Bennett.[7]

The present study reviews data available about tetanus recorded in the medical records of Lexington's hospitals from 1950 to 1968, and shows the tetanus situation in the Bluegrass area.

Lexington, Kentucky occupies a central position in the Eastern United States. It is a link between the industrial Great Lakes region of the North and the agricultural South, as well as a link between the urbanized area of the East and the rural Midwest. It is situated in Central Kentucky, the "Heart of Bluegrass", which is the center of the plain covering the central sub-region of the Bluegrass. In addition, Lexington is the hinterland apex of Cincinnati, Louisville and Lexington regional triangle.

The population of metropolitan Lexington (i.e., Fayette County) obtained from the U. S. Census in 1950 was 100,746 with a non-white percent of 17.3. The last U. S. Census conducted in 1960 indicates a population of 131,906 for the same area. The total non-white population in 1960 was given as 15.3 percent of the total. Estimates, undertaken on the basis of this figure and other historical data, give a population for mid-year 1964, 1965, and 1966 of 148,700, of 153,000, and 158,000 respectively. Thus the annual increment to the population has been estimated in the range of five to six thousand[8]. Based on these data, the population for metropolitan Lexington could be estimated at 169,000 in mid-year of 1968. Fayette County contains a total of 283 square miles.

In Lexington, there are one College of Medicine with one University Medical Center and four other general hospitals.

†*From the department of community medicine, University of Kentucky Medical Center, Lexington*
**Post-doctoral fellow*
***Post-doctoral fellow*
****Professor and acting chairman*

Sources of Data

The data presented in this study were secured from the medical record rooms of the five general hospitals of Lexington, Kentucky. Complementary data were obtained in the Commonwealth of Kentucky, State Department of Health in Frankfort.

A total of 40 tetanus cases was recorded in the Lexington hospitals from 1950 to 1968.

Results and Comments

The characteristics of the cases found were the following:

Age: While in other countries, the problem of tetanus neonatorum is so important[9], in the data recorded in Lexington's hospitals, only two cases of tetanus neonatorum were found. This represented only five percent of the total. It was found that 50 percent of the cases occurred among people under 15 years of age and 25 percent in people over 65. The percentage under 15 years is practically the same (54 percent) verified by Portsmouth in East Africa.[10] But while in that region of Africa the population under 15 years runs about the same percentage (50 percent), in Kentucky the population under 15 years was 30.8 percent in 1950 and 32.2 percent in 1960. For Fayette County the same data were respectively 22.4 percent and 29.2 percent.[11]

Table 1 shows the age of the tetanus cases recorded in Lexington's hospitals.

TABLE 1: TETANUS CASES RECORDED IN LEXINGTON HOSPITALS FROM 1950 TO 1968, BY AGE

Age	Number of Cases
Newborn	2
Under 5 years	1
5-9 years	10
10-14 years	7
15-19 years	3
20-24 years	1
25-29 years	0
30-34 years	1
35-39 years	2
40-44 years	0
45-49 years	1
50-54 years	1
55-59 years	0
60-64 years	1
65-69 years	3
70-74 years	3
75-79 years	2
80 years and over	2
TOTAL	40

TABLE 2: TETANUS CASES RECORDED IN LEXINGTON HOSPITALS FROM 1950 TO 1968, BY SEX AND COLOR

	Males	Females	Total
White	17	12	29
Non-white	7	4	11

Sex and Color: In Table 2, the patients were distributed in four groups according to sex and color. While in the population of Fayette County and surrounding counties, the percent of non-white was not more than 18, in the cases recorded this percent increased to 27.5. According to sex, 60 percent were male.

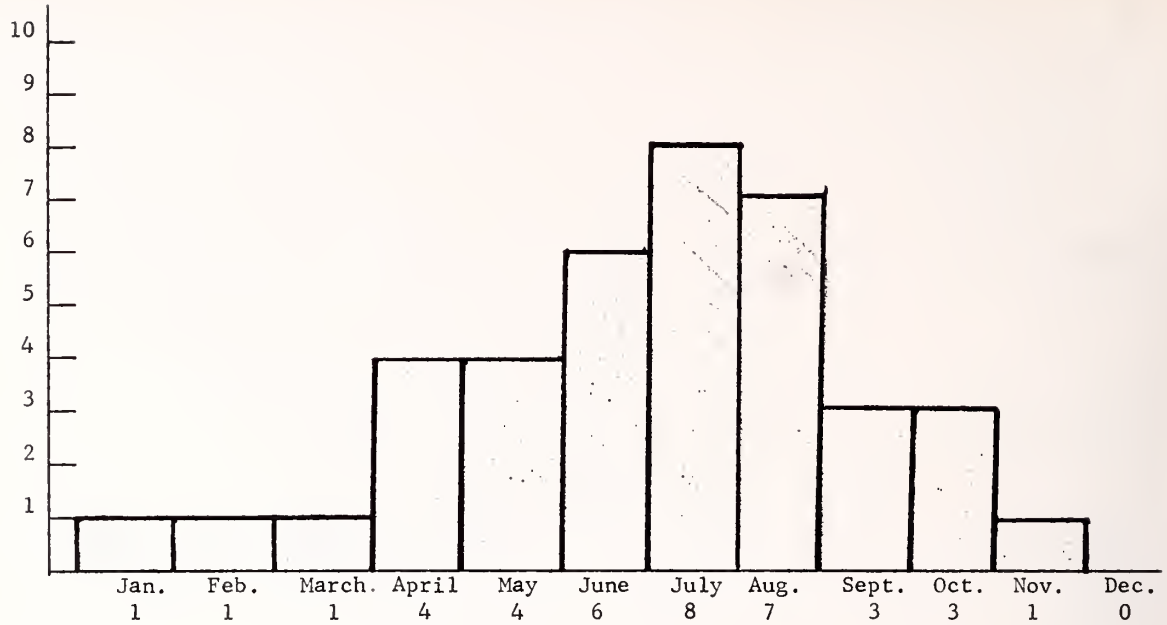
As Veronesi[9], the authors believe that the higher frequency of tetanus in males is a consequence of the higher possibility of the man being injured in his activities or the risky games played by the boys, and that when one apparently higher incidence of tetanus is related to a color, other elements have to be analyzed. Unfortunately, in this review the authors could not find data that made it possible to analyze other aspects, as socio-economic level of life, which might be related to this higher incidence.

Monthly Distribution of Onset: Figure 1 shows the frequency of tetanus cases recorded in Lexington's hospitals, according to the month of onset. As expected, there was a higher frequency in the summer months as three-fourths of the cases occurred in the months of April through September.

Immunization History: Among the 40 cases, only one case was found with immunization history against tetanus in the past. This was a 73-year-old female, who was reported to have received basal immunization against tetanus. A booster was given to her on the same day that she was injured but despite this, tetanus appeared 10 days later and the disease was fatal. As the information of immunization came from the patient, it was possible that some mistake had been made.

From all the other patients, a history of immunization was either not obtained, or suggested inadequate protection.

One other point that should be made is that the Veterans Administration Hospital was the only one where no case of tetanus was recorded. As it is known, all the veterans were immunized against tetanus in the Army.



Unknown 1; Total Cases, 40

FIGURE 1. Tetanus Cases recorded in Lexington hospitals from 1950 to 1968 by month of onset

Case Fatality Ratio: The case fatality ratio was found to be 30 percent from 1950 to 1968. This was lower than the case fatality ratio recorded for all the United States from 1965 to 1966, which was 68 percent.[6]

In order to know if the case fatality ratio was declining from 1950 to 1968, the cases were distributed in three periods and the case fatality ratio was calculated. The results are shown in Table 3. No significant difference was observed among the three groups. This fact is in concordance with the same observation pointed out in the Tetanus Surveillance Report for all the United States from 1950 to 1966.[6]

This suggests that strong efforts to reach universal tetanus immunization have to be made, because such immunization is the only means by which tetanus may be eliminated. On the other hand, it also indicated that the search for new treatment must be continuous.

The case fatality ratio for patients less than 50 years of age was 17.8 percent as compared with 58.3 percent for age group over 50. The national ratios in 1965-1966 were 55.4 percent and 76.4 percent respectively.[6]

The discrepancy between the case fatality ratio of the tetanus cases recorded in Lexington's hospitals and the national ratio brought about in the report of the National Communicable Disease Center may be explained by an inherent bias in the reporting of diseases. About this fact in the Tetanus Surveillance[6] Report it is written: "Secondly, an inherent bias in the reporting of tetanus may exist to the extent that only the more serious cases that occur are reported." It seems that the data presented in this study support that statement.

The case fatality ratio when the tetanus cases recorded in the Lexington hospitals were separated by color were 26.2 percent for white and 36.4 percent for non-white.

Finally, the case fatality ratio distributed in three age groups is shown in Table 4.

Length of Stay in the Hospital: Table 5 shows the length of stay in the hospital of the surviving cases. On the average, the length of stay of the surviving cases was 21.8 days.

The cost of one day's hospitalization for one tetanus patient, with intensive care, runs about

TABLE 3: SURVIVAL AND DEATH CASES OF TETANUS RECORDED IN LEXINGTON HOSPITALS FROM 1950 TO 1968

	1950-1955	1956-1961	1962-1968
Survival Cases	9	7	12
Death Cases	4	3	5
TOTAL	13	10	17
Case Fatality Ratio	30.8%	30.0%	29.4%

TABLE 4: SURVIVAL AND DEATH CASES OF TETANUS RECORDED IN LEXINGTON HOSPITALS FROM 1950 TO 1968 BY GROUPS OF AGE

	Under 15 years	16-65 years	66 years and over
Survival Cases	15	8	5
Death Cases	5	2	5
TOTAL	20	10	10
Case Fatality Ratio	25.0%	20.0%	50.0%

TABLE 5: LENGTH OF STAY IN THE HOSPITAL OF THE SURVIVING TETANUS CASES RECORDED IN LEXINGTON HOSPITALS FROM 1950 TO 1968

Number of Days in Hospital	Number of Cases
10 or less	7
11-20	10
21-30	4
Over 30	7

$100. Then the recovery of one tetanus case costs more than $2,000. This amount is more than enough to give complete immunization to 2,000 persons.

Distribution by County: The counties where the tetanus cases occurred are shown in Figure 2.

Analyzing the number of cases of Fayette County and the neighboring counties, 17 cases of tetanus in Lexington's hospitals came from: Fayette, 10; Bourbon, two; Clark, two; Jessamine, three; Scott and Woodford, none. In the same period, the cases of tetanus reported to the State Department of Health from these counties were the following: Fayette, one; Bourbon, five; Clark, one; Jessamine, Scott, and Woodford, none. Of the 17 cases from the Lexington hospitals, only four were reported to the State Department of Health, i.e., only 23.5 percent of the total. If the Fayette County figures are taken alone, the percentage declines to 10 percent.

Trends: While it seems definite that more and more of the population is being immunized against tetanus, a review of Table 6 shows no tendency of decline in the number of cases admitted to hospitals in Lexington. Indeed, 1965 was the highest year recorded with six cases. Nor does the lack of reporting seem to be improving since a case of tetanus admitted in February, 1969 remains unreported to the State Health Department.

TABLE 6: TETANUS CASES RECORDED IN LEXINGTON HOSPITALS BY YEAR OF ADMISSION AND SEX

Year	Male	Female	Total
1950	0	0	0
1951	0	1	1
1952	3	0	3
1953	3	1	4
1954	0	0	0
1955	3	2	5
1956	2	0	2
1957	1	1	2
1958	2	1	3
1959	0	0	0
1960	2	0	2
1961	0	1	1
1962	2	2	4
1963	0	0	0
1964	0	0	0
1965	2	4	6
1966	2	2	4
1967	2	1	3
1968	0	0	0
TOTAL	24	16	40

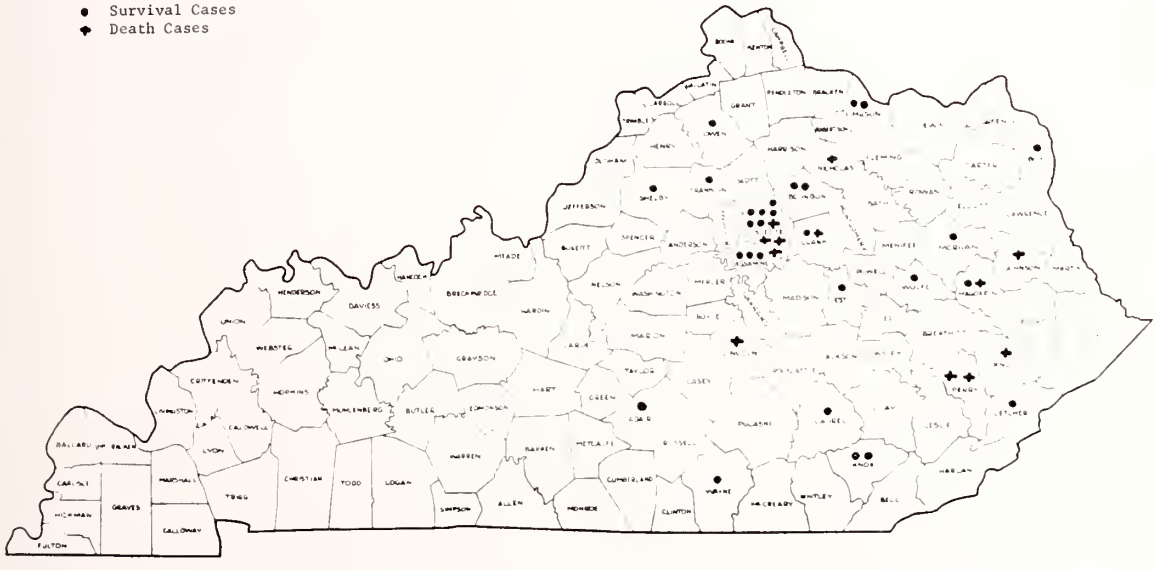


FIGURE 2. Distribution by county of recorded cases of tetanus in Lexington hospitals from 1950 to 1968

Conclusions and Summary

Subject to the limitations of a survey of hospital records, some conclusions about tetanus can be made. According to age it was shown that the more susceptible were under 15 and over 65 years of age. In respect to sex and color, the predominance in the male and in the non-white population was verified. About seasonal predominance, it was found that the majority of cases appeared in the summer. The case fatality ratio showed no significant difference in the period from 1950 to 1968. On the other hand, it was shown that tetanus is more dangerous when it appears in persons over 50 years of age. The average length of stay in the hospital was 21.8 days, which meant that the median cost of the recovery of one tetanus patient was in the neighborhood of $2,000. From the comparison with the data of the State Department of Health it was verified that only 23.5 percent of the total cases of tetanus recorded in Lexington's hospitals which came from the counties of Fayette, Bourbon, Clark, Jessamine, Scott, and Woodford were reported.

These results are not too different from others found in the literature. But they show that the prevention of tetanus must be emphasized. Efforts have to be pushed to reach universal tetanus immunization even in the developed countries in order to make tetanus no longer a problem. On the other hand, it is disturbing to note that despite the different management of the patients from 1950 to 1968 no significant differences in mortality resulted. It is clear that research in improved methods of treatment should be encouraged.

References

1. Bytchenko, B. Tetanus as a World Problem. In Eckmann, L. *Principles on Tetanus.* Proceedings of the International Conference on Tetanus. Bern. July 15-19, 1966. Bern and Stuttgart: Hans Huber Publishers, pp. 21-41, 1967.
2. Moore, R. M. and Singleton, A.D. Tetanus at the John Sealy Hospital. Observations upon the Distribution of Tetanus Throughout the United States. *Surg. Gynec. & Obst.,* 69: 146-154, August, 1939.
3. Axnick, N.W. and Alexander, E.R. Tetanus in the United States: A Review of the Problem. *Am. J. Pub. Hlth.,* 47: 1493-1501, December, 1957.
4. Heath, C.W., Jr., Zushman, J. and Sherman, I.L. Tetanus in the United States, 1950-1960. *Am. J. Pub. Hlth.,* 54: 769-778, May, 1964.
5. Albrecht, R.M. Tetanus in New York State, Excluding New York City. Incidence and Control. *New York State Journal of Medicine,* 66: 487-492, February, 1966.
6. National Communicable Disease Center. Tetanus Surveillance. U.S. Department of Health, Education and Welfare. Public Health Service. Bureau of Disease Prevention and Environmental Control. *Report No. 1,* February 1, 1968.
7. La Force, F.M., Young, L.S., and Bennett, J.V. Tetanus in the United States (1965-1966): Epidemiologic and Clinical Features. *New Engl. J. Med.,* 280: 569-574, March, 1969.
8. City-County Planning Commission, Lexington and Fayette County, Kentucky. A plan for Land Use.
9. Veronesi, R. Epidemiology of Tetanus. In Echmann, L., *Principles on Tetanus* Proceedings of the International Conference on Tetanus. Bern, July 15-19, 1966. Bern and Stuttgart: Hans Huber Publishers, pp. 43-48, 1967.
10. Portsmouth, O.H.D. Tetanus in Nyeri. *East African Medical Journal,* 40: 643-648, December, 1963.
11. Brow, J.S. and Ramsey, R.J. *Kentucky's Population in the 1960's, A County Data Book,* Lexington, University of Kentucky, Agricultural Experimental Station, Department of Rural Sociology. Resource Development Series, 9. September, 1963.

Whiplash Abdominal Injury

Romeo S. Berardi, M.D.*

McDowell, Kentucky

Abdominal injuries are usually classified as penetrating and non-penetrating. Of the latter, a particular type of injury which we feel is original in concept and which we have named "Whiplash" Abdominal Injury is described.

ABDOMINAL injuries are generally classified as penetrating and non-penetrating. This latter can be produced by a crushing force, a shearing force, and by a compressive and rapid decompressive mechanism.[1] A recent case has brought to our attention the importance of emphasizing particular injuries resulting from a shearing force which we have named "whiplash" abdominal injuries. To our knowledge this concept in regard to certain intra-abdominal injuries is original.

General Considerations

In viewing the abdominal contents, it becomes obvious that certain organs are more susceptible to "whiplash", such as those which are relatively mobile and attached by a mesentery. The more mobile mesenteric-attached segment of the gastrointestinal tract is the small bowel, and this indeed is the most vulnerable to such an injury.

The root of the small bowel mesentery extends from the left side of the body of the second lumbar vertebra obliquely downward and somewhat to the right in front of the pars ascendens duodeni, the aorta abdominalis, the inferior vena cava and the right ureter to the right articulatio sacroiliaca. The length of the mesentery measured from the flexura duodenojejunalis on, is longest on those loops which descend into the true pelvis and then becomes shorter. It is narrower at its starting point, then broadens fairly suddenly and presents many markedly zig-zag shaped tortuous folds and is finally attached to the whole extent of the small bowel. The mesentery consists of a layer of connective tissue, lamina mesenterii propria, in which are situated vessels, lymph nodes, nerves, and masses of fat and is covered on both sides by the tunica serosa.[2]

The vessels, especially the arteries, convey to the mesentery a certain "stiffness" and radial routes along which the effects of the "whiplash" will have the greatest impact. Each artery bifurcates and forms archlike anastomoses with the branches of neighboring vessels; the branches arising from these form further anastomoses and so on until two to five series of anastomoses follow upon one another. The last numerous branches of nearly equal size and almost equidistant from one another go to the small intestines. The last iliac artery unites with the ileocolic artery.[3]

The mechanism of action in producing this type of injury is the same as that resulting from the cracking of a whip. The points of relative fixation are represented normally by the duodeno-jejunal junction and the ileocecal valve. Any adherent loop of bowel can also act as a point of fixation. These areas are the most likely to be injured in blunt trauma to the abdomen,[4] but not necessarily so in "whiplash" injuries. In this type of injury the point of fixation is represented by the root of the mesentery and the shearing force is transmitted along the somewhat radially arranged arteries. This "whiplash" of the small bowel creates a wave-like motion which in turn is transmitted to the bowel wall. The point of greatest impact will be precisely in the area of sharpest and most forceful point of the wave-like motion created by the "whiplash" effect.

The production of such a force can conceivably be produced by vehicular accidents. The possible "whiplash" movements of the small bowel can be in a to and fro manner, one of side to side motion, and in a cephalad-caudad direction. The importance of such a mechanism lies in the fact that no direct contact with the abdominal wall is needed. The better known "whiplash" injury to the cervical spine can be used as an appropriate analogy.

*Chief of surgery, Daniel Boone Clinic, McDowell Regional Hospital

Depending on the point of greatest impact, the following injuries are possible:

1) Major Force—rupture of primary mesenteric artery and/or detachment of mesentery from the bowel wall or at its root.

2) Moderate Force—rupture of secondary artery and/or tear of mesentery.

3) Minor Force—rupture of smaller caliber artery with resulting mesenteric hematoma or transient bowel wall ischemia.

Symptomatology

Depending on the type of injury, the symptomatology will vary from that of a shock-like picture to one which will elude complete clinical detection. The first important consideration is to be aware that such injuries are possible, especially in the multiple injured patient who has sustained no discernible external abdominal trauma. The patient who is in shock when first seen presents lesser difficulties than one who is in coma and not in shock.

In the first type of injury in which a major artery is ruptured, symptoms may be those of profound shock secondary to blood loss. Should this be of a lesser magnitude, then signs and symptoms of hypotension may be present. In either case one might expect moderate to severe abdominal pain (secondary to intra-abdominal blood loss and not to trauma) and tenderness to palpation and percussion. Pain and tenderness may however be completely absent. Rigidity may or may not be present. Bowel sounds may be normoactive at the onset and later become hypoactive and then silent. The patient may continue to pass flatus and indeed may have bowel movements. This latter is, however, more consistent with detachment of the mesentery from the bowel wall with which blood loss is usually of much lesser magnitude since much smaller caliber arteries are involved.

Should the mesentery become detached from the small bowel, bleeding as indicated above will be of lesser severity. Therefore, signs of shock will be absent. Hypotension may or may not be present, as will be true with abdominal pain and tenderness. As a matter of fact, pain and tenderness may be completely absent until impending perforation or perforation of the bowel ensues. Bowel sounds may be at the onset normoactive, then become hypoactive and finally silent. The extent of mesenteric detachment is variable depending on the arc of the whiplash and the force produced, but presumably rarely greater than six-seven inches.

Both of the above described injuries may (very probable) or may not (less probable) result in necrosis of the involved segment of small bowel. Should this occur, and this is most important, signs of peritoneal irritation will usually be present, but may be clinically absent entirely. Indeed, the first indication that the patient may have sustained an intra-abdominal injury may present some few hours after admission to the hospital and then only in the form of what appears to be a paralytic ileus. Further comment on this will be made under the heading of diagnosis.

In the second type of injury (moderate force), the patient may or may not exhibit signs of hypotension; may or may not have pain or abdominal tenderness and may (less probable) or may not (most probable) develop necrosis of the involved segment of small bowel with subsequent ileus.

In the third type of injury (minor force), the resulting injury will usually escape clinical detection and result in complete self resolution without any significant ill effects.

Since this type of abdominal "whiplash" injury will occur more frequently from vehicular accidents, associated injuries will not be at all uncommon. Therefore, a greater degree of suspicion is necessitated.

Diagnosis and Indications for Exploratory Laparotomy

In the first type of injury (major force), abdominal pain, tenderness and other signs of peritoneal irritation, signs and symptoms of shock or hypotension will lead one to suspect an intra-abdominal injury of significance to indicate exploration. Should there be any doubt, a four quadrant abdominal paracentesis or catheter aspirations[5] of the peritoneal cavity are indicated. Should this latter be negative, then laparotomy might still be indicated depending on the clinical findings. Should further observation be decided, then frequent abdominal examinations must be carefully performed. If an abdominal catheter is left in place, then repeated aspirations should be carried out. In this type of injury, an X-ray film of the chest and abdomen, which is always in-

dicated in the multiple injured patient and should be obtained in these patients, will, however, not show much of any significance at the onset. Later films of the abdomen will invariably demonstrate a picture of paralytic ileus.

In the second type of injury (moderate force), the same considerations are indicated. In the third type (minor force), the entire injury will usually escape clinical detection and resolve without any significant sequelae. The so-called ischemic stenosis of the small bowel may very well be a late sequela of this type of injury.

It is postulated that blood loss in this type of injury, although it might be of major import, is usually not severe enough to produce a state of profound shock. As a matter of fact, it is completely and reasonably possible that the first indication that the patient has indeed sustained an intra-abdominal injury is the appearance of a paralytic ileus some few hours after admission to the hospital. Because it is believed that this latter presentation is not at all uncommon, a word must be said about this.

In the multiple injured patient who exhibits no signs or symptoms of having sustained an intra-abdominal injury when first seen, but who later develops a clinical and X-ray picture of paralytic ileus, a complete reassessment of the patient's abdomen must be undertaken. Should repeated abdominal examinations fail to reveal any signs of peritoneal irritation, and should the ileus not be completely and satisfactorily explained by other sustained injuries, further abdominal investigation is mandatory. This will usually resolve itself to the consideration of whether abdominal paracentesis should be carried out. Although one realizes the hazard of such a procedure in the presence of an ileus,[6] we feel that with adequate precautions it can be safely performed. It would probably be safer to employ the cathcter technique under these circumstances. This relatively simple procedure may indeed determine the necessity of immediate abdominal cxploration in an otherwise negative abdomen. It also, if positive, will lessen the period of procrastination which, if continued, might prove to be diastrous for some patients. The reality of bowel necrosis must always be kept in mind in such injuries.

Should abdominal paracentesis be negative, then further observation would seem to bc a reasonable consideration, unless other clinical parameters state otherwise. Once signs of peritoneal irritation ensue, then laparotomy is mandatory. Should no such signs develop after a negative abdominal paracentesis, and should the ileus not be adequately explained, and further observation be decided, then it would seem reasonable to conclude that if resolution of the ileus is not accomplished within a period of 48 hours, laparotomy is indicated.

Comments and Conclusions

The main characteristic of "whiplash" injuries to the abdominal content is that there is no direct contact with the abdominal wall. Thc patient when first seen may exhibit no cvidence of abdominal injury, either subjectively, as in the form of pain, or objectively, as in the form of tenderness to palpation or percusion, abdominal mass, shifting dullness, and abnormal bowel sounds. The clinical course can be very deceptive for it may be characterized by extreme subtleness and insidiousness. A serious consideration of abdominal investigation may not present itself until some few hours after admission when a paralytic ileus appears. This may still delay investigation should the patient have sustained an injury which in itself might produce an ileus; i.e. pelvic fractures, fractures of the transverse lumbar processes, fractures of the lumbar vertebral bodies, etc. This may become even more nebulous should the patient not exhibit any change in his general condition and should thc abdomen remain consistently negative to repeated abdominal examinations, until necrosis of the bowel with its ensuing complications makes itself manifest. Further delay can be had, if the patient does indeed pass flatus freely and does have bowel movements, giving one the impression that the ileus is indeed resolving itself.

The major consideration is the ileus and whether this can be adequately explained from other sustained injuries. A high index of suspicion is the key-note to the possible existence of this type of "whiplash" intra-abdominal injury.

References

1. Ballinger, II, W.F., Rutherford, R.B., Zuidema, G.D., *The Management of Trauma:* W. B. Saunders Co., Philadelphia and London, 1968, Chapter XI, p. 347.

(Continued on Page 528)

SPECIAL ARTICLES

OEO Programs in Kentucky
A Progress Report

THE KMA Committee on Appalachian and OEO Programs has met with the directors of OEO Programs in Kentucky. In these meetings, the committee members were interested in the diversity of approaches these various programs are taking.

In order to keep the membership informed of the operation of these programs, the committee requested that *The Journal* publish the following three reports on the OEO Programs in Kentucky.

Frank M. Gaines, Jr., M.D., Chairman
KMA Committee on Appalachian and OEO Programs

Leslie County Health Program

MARY P. FOX, M.D.

IT IS generally maintained that poor health is a major contributor which deters one's ability to achieve maximum effectiveness in education, employment and social worthiness. Therefore, it was felt by the Leslie County Development Corporation that a two-fold purpose could be realized through a grant request to the Office of Economic Opportunity. First, diseases which affect the whole man would be diagnosed and provision for treatment would be available to the poor of Leslie County, and secondly, coordinated effort of comprehensive health services would draw upon total (community) resources to enable the poor to move into the mainstream of American life.

The Leslie County Development Corporation, in conjunction with the Leslie County Health Department and the Kentucky Department of Health, submitted a one-year grant request to the Office of Economic Opportunity, Washington, D. C., entitled "Community Action Health Project for Leslie County."

This project was considered as a pilot program for the Hazard Regional Health Center and could serve as a prototype for other large-scale programs. Locally, this program would build upon present health facilities so that more complete permanent community health would emerge.

This grant was officially approved September 2, 1965, and screening of patients commenced in mid-November.

In the fall of 1966, a multi-county Committee Action Agency was formed. The counties of Leslie, Knott, Letcher, and Perry were incorporated to become the LKLP Community Action Council, Inc. The LKLP became applicant agency for the health program and the Leslie County Development Corporation became delegate agency with the responsibility for policy and program operations.

The program is directed toward four objectives:

1. To conduct multi-phasic screening and diagnose disease in the population, to provide funds for further diagnostic procedures for appropriate patients, and to establish a referral center which would place patients in existing state and voluntary programs for treatment;

2. To provide community mental health services for diagnosis, follow-up, and prevention of the pressing mental health problems;

3. To study environmental, family, and personal health needs and to institute a health education program for the people of Leslie County to acquaint them with the basics of environmental sanitation and to motivate them to follow better health practices, including the use of available health services; and

4. To implement home care instruction and fundamentals of physical and mental health based on the findings of the multi-phasic screening team.

In delivery of medical services to the people of Leslie County, the rugged topography and sparse population distribution of the area to be served impose severe problems in communication and transportation. These problems are of such magnitude as to make impractical 24-hour service under one roof. The only practical solution seems to be continued utilization of the available medical and dental personnel and facilities in the county and in the surrounding counties in order to be able to provide the needed services to program beneficiaries. The physician employed by the program provides full-time services to the program and also provides

(Continued on page 511)

Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each toblet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "potient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when o new mother needs expert odvice for the future, so she can spoce her children ond limit her family.

It is olso the most opportune time, since she is conveniently present in the hospitol, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediotely after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended thot nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal ogents in orol controceptive pills has been identified in the milk of mothers receiving these drugs. The long-ronge effect on the nursing infont connot be determined ot this time.

Indication—Oral cantraception.

Contraindications—Thrombophlebitis, thromboembolic disarders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, knawn ar suspected estragen-dependent neoplasia, undiagnosed abnarmal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrambophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombasis); if present or suspected discontinue the drug immediately.

British studies reparted in April 1968[1,2] estimate there is a seven- to tenfold increase in martality and marbidity due to thromboembalic diseases in women taking aral contraceptives. In these contralled retrospective studies, involving 36 reparted deaths and 58 haspitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and nan-users were highly significant. The conclusians reached in the studies are summarized in the table below:

Comparison of Mortolity ond Hospitolizotion Rotes Due to Thromboembolic Diseose in Users ond Non-Users of Oral Contraceptives in Britoin.

Category	Martality Rates		Hospitalization Rates (Marbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic diseose may differ.

Discontinue medication pending exomination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migroine. Withdrow medicotion if papilledemo or retinol vascular lesions ore found.

Since the sofety of Ovulen in pregnoncy has not been demonstroted, it is recommended that pregnancy be ruled out for ony potient who hos missed two consecutive periods before continuing the contraceptive regimen. If the patient hos not adhered to the prescribed schedule the possibility of pregnoncy should be considered at the first missed period.

A smoll froction of the hormone ogents in orol contraceptives has been identified in the milk of mothers receiving these drugs. The lang-range effect an the nursing infant cannat be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and passibly liver function tests may be affected by Ovulen. Therefare, it is recommended that such tests if abnarmal be repeated after the drug has been withdrawn for twa manths.

Pre-existing uterine fibromyomas may increase in size under the influence of progestagen-estrogen preparations.

Because these agents may cause same degree of fluid retention, conditians which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthraugh bleeding, and all irregular vaginal bleeding, consider nonfunctianal causes. Adequate diagnastic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history af psychic depressian and discontinue the drug if severe depression recurs.

Any passible influence af prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucase tolerance has occurred in a significant percentage of patients on aral cantraceptives. The mechanism of this decrease is obscure. Far this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because af the effects of estragens on epiphyseal clasure Ovulen shauld be used judiciously in young patients in whom bone growth is not complete.

The age af the patient constitutes no absolute limiting factor, althaugh Ovulen therapy may mask the onset of the climacteric.

The pathalogist shauld be infarmed af Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciation has been shown between use of aral cantraceptives and the following serious adverse reactians: thrambaphlebitis, pulmonary embolism.

Although available evidence is suggestive of an assaciation, such a relatianship has been neither canfirmed nar refuted for the fallowing serious adverse reactians: cerebravascular accidents, neuro-ocular lesians, e.g., retinal thrombosis and optic neuritis.

The fallawing adverse reactions are known to occur in patients receiving oral cantraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdaminal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flaw, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretian), change in weight, changes in cervical erasian and cervical secretions, suppressian of lactation when given immediately post partum, chalestatic jaundice, migraine, allergic rash, rise in blaad pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reparted in users of oral cantraceptives, an assaciation has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrame, headache, nervausness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruptian, itching. The following labaratory results may be altered by orol contraceptives: hepotic function: increased sulfobramophthalein ond other tests; coogulation tests: increose in prothrombin, Foctors VII, VIII, IX ond X; thyroid function: increase in PBI and butanol extroctable protein baund iodine, and decrease in T^3 uptoke values; metyrapone test; pregnanediol determination.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began
G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

Parke, Davis & Company, Detroit, Michigan 48232

$6565

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

(Continued from Page 504)

after-hour and emergency services for patients at the Frontier Nursing Service Hospital.

The present system of operational procedures is that patients may receive treatment, hospitalization, specialized consultation, further diagnostic work-up, or home health services as needed. Patients are referred to the family physician for treatment and on-going follow-up and comprehensive care. On such cases, where there is no family physician, referrals are made in consultation with the patient, affording him the opportunity to select the physician of his choice for his immediate family unit.

The dental program functions in two areas. Elementary school children are served by field clinic units. A completely comprehensive program is made available to the children of indigent recipients, and the indigent adults and high school children are provided dental care through the private dental offices of their choice. Fees for these services are based on the established usual and customary fee for each office.

Clinical nursing service of the depth and scope comparable to that of a first-rate private clinic is provided for L.C.H.P. patients. The staff is especially alert to the need for counseling patients following their visits to the clinic physician. Home visits by field nurses on all patients who have received treatment, hospitalization, or referrals is provided. They coordinate their activities closely with other field workers and allied agencies.

The out-reach program includes health education and home-maker services. The health education portion centers around the home front worker concept. These persons are able to effectively approach the problem of education and motivation of the recipients who are most in need of the program's services. These workers are responsible for motivating the people to take advantage of the program, make clinic appointments and arrange transportation, make follow-up visits when necessary, to encourage recipients to accept further treatment, and to encourage improved general and specific health concepts such as sanitation, safety, dental care, preparation and storage of food and hygiene.

The home-makers services include home-making, nutrition, budgeting, sanitation and sewing, and are available to those families needing specific help in these areas in order to improve their environment, especially in those cases when the mother is incapacitated.

The county health department sanitarian supervises the program's assistant sanitarian in environmental health services. They supervise the operation of sanitary land fills following their construction, the building of seepage pits, septic tank and drainage fields, and sanitary privies. Their work force is provided by personnel from O.E.O. and Department of Labor work programs.

Until the recent organization of the Regional Mental Health - Mental Retardation program, the L.C.H.P. had major responsibility for holding Mental Health Clinics. The program also provided funds and other supportive services for the appropriate personnel to carry out job tasks.

The operation of Hope House, a school for the retarded and handicapped, is the responsibility of the L.C.H.P. Seven teachers, one supervisor, one cook, and four transportation aides are involved. Out-of-school Neighborhood Youth Corp aides are assigned to this component for supportive services.

To insure the best utilization of all available resources, the social services personnel work closely with all other components and agencies in an effort to provide comprehensive health service for the indigent population. Their activities include preparation of social history, assistance to patients referred to private physicians, assistance to patients referred to other agencies, follow-up on all referrals and work with other program members to be alert to the social implications of a patient's surroundings.

On-the-job training for low-income employees is on a continuous basis. A formal nurse's aide training program for six months in program year 1968 was completed. A training concept is presently being developed for 1970 which will allow low income residents to fill gaps in the delivery of health services.

The criteria for determining eligibility for medical care funds is basically the same as that of Title XIX. However, program funds are used as a supplement in surgical cases when recommended by a physician. In these cases, the amount will be governed by rates used by the Bureau of Rehabilitation. Prosthetic devices, supplementary drug formulary services not covered by other agencies will, with special authorization from the program's Medical Committee, be considered.

Since the beginning of the program, 12,495 persons have been screened. Of this figure 10,141 are new encounters and 2,354 have been through the clinic for the second time.

Southeastern Kentucky Regional Health Demonstration Project For 68-69

Harold L. Bushey, M.D.

THE first year the demonstration emphasized major construction of needed facilities in the area. Other important programs started were the Home Health Care and the Multiphasic screening. Both of these programs have been implemented and are actively at work in most of the counties included in the 11-county demonstration project.

The emphasis for 1968-69 is as follows (listed according to priority):

1. Emergency Service Systems. This will include some construction and up-dating of current facilities. A communications system is being proposed linking all the hospitals of the area and ambulance service, etc., by short wave.

2. Comprehensive mental-health retardation services for the Wilderness Road Area should include the construction of facilities and implementation of mental health facilities, mental retardation programs, and a sheltered workshop.

3. Buckhorn Lake Area is proposing services for out-lying areas providing for essential diagnostic services and convalescent long-term in-patient services for ambulant out-patients.

4. Ambulant care centers proposed in Harlan, Middlesboro, Pineville, and Manchester.

5. Health manpower development request for five groups, including the Frontier Nursing Service for Hyden; the Southeastern Community College at Cumberland, the Hazard Community College at Hazard; the Appalachian Regional Hospital, Inc., Office of Education; and the Community College Foundation, Inc., of Hazard. These groups have various proposals to increase the health manpower by local recruiting, educating and training programs.

6. Solid waste disposal proposal is requested by the State Department of Health developing the regional system for the solid waste disposal.

7. Extended care and other in-patient facilities. The applications in this category are from the Appalachian Regional Hospital in Middlesboro and the Southeastern Kentucky Baptist Hospital in Corbin, with the preference being extended care beds in Middlesboro and acute medical and surgical beds with enlargement for ancillary departments in Corbin.

8. A comprehensive mental health retardation service for the Pine Mountain Area. This is similar to the previously mentioned proposal for the Wilderness Road Area. However, it is anticipated that only the beginning development of this program in the Pine Mountain Area will be accomplished this year.

These proposals are to be presented to the three councils in final form, then submitted to the Southeastern Kentucky Regional Health Demonstration Project for final approval locally. The accepted proposals will be reviewed in Washington and final approval will depend upon the money available, priorities, and the worthiness of the various proposals presented. The proposals from the other states in the Appalachian region are also to be considered and will share the available money.

Neighborhood Health Center, Louisville

Harvey Sloane, M.D.

THE Park-DuValle Neighborhood Health Center opened its doors for service February of 1968. Services were commenced on a partial basis because of inadequate space and staff. However, in May of 1968, medical, dental, nutritional, mental health, and social services were available to the total eligible population of the Park-DuValle community. In July, 1968, night (until 1:00 a.m.) weekend medical services and 24-hour transportation were commenced.

To date, the Neighborhood Health Center has had approximately 31,000 patient visits, including home visits by the staff, and 84 percent of the eligible households have received service. The full complement of professional staff has been recruited, and in March of 1969 the Health Center completed its move into the renovated apartment buildings adjacent to the temporary facility.

Utilization of services by the patients increased dramatically after entrance into the new facilities. Emergency ambulance service is presently being worked out with the Louisville Police Department, as well as General Hospital. The Health Center is involved in outreach programs with the Park-DuValle schools and general community to provide more comprehensive follow-up and care.

Funds for the Health Center are from the Office of Economic Opportunity, Public Health Service, Vocational Rehabilitation, Department of Housing and Urban Development,. Labor Department, Louisville City Administration, Crusade for Children, and three local private foundations (WAVE, Byck Foundation, and the Courier-Journal and Louisville Times).



Medicaid Today

Whatever may be our objections to Medicare they do not apply to Medicaid which is a plan for medical care to indigent persons financed by the state with funds supplemented by the federal government. The Kentucky Medical Association endorsed this program and from its inception until now has sought to cooperate completely in its implementation. That we have received, and perhaps merited, criticism locally and nationally for violations and abuses is a matter of regret and humiliation but one which we can and will correct.

That we as a state are not alone in sustaining such charges is some consolation but no valid excuse. The enormous and mounting expense of the program has caused some states to discontinue it altogether. We do not intend to do that lest large percentages of our people would actually be deprived of badly needed medical care. The criticism that the system is full of inequities and is charged with poor management is no cause for discontinuing it unless a better plan for providing care to the medically indigent is developed.

The *A.M.A. News* of June 23, 1969 carries an article on its editorial page under the title "Medicaid: A Sick Program" which is a summary from the *Chicago Tribune*. It is informative and revealing enough but, in our opinion, too severely critical both of the program itself and of physicians participating in it. The conclusion is that "it is time now for doctors themselves, thru established medical organizations, to come up with suggestions for a system which will make medical care more available to the needy and at the same time be less tempting to cheaters. A healthier program would be less troubled by vultures." Perhaps true, but that is a big order which we as a profession cannot immediately fill. We must for the present exert ourselves to correct our own abuses and at the same time improve the operation of the present system. This we are in the process of doing.

On June 5, 1969 the Technical Advisory Committee on Physicians Services met with representatives of the Medical Assistance Divisions of the Kentucky State Departments of Health and Economic Security to consider statistical information and reports of alleged violations of the program by certain physicians. This material was presented in a letter June 9 to Mr. Merritt S. Dietz, Jr., Commissioner, Kentucky State Department of Economic Security, who has financial responsibility for state operation of Medicaid. On June 26 this matter was considered by the State Board of Health with the physicians involved attending and given a hearing. Mr. Dietz and members of his department were present and participated freely in discussions. It was evident that all concerned are sincerely committed to improvements in our program, in a wider search for violations of its provisions, and in correction of abuses where found.

It was quite apparent from our prolonged discussions that alleged violations and misuse of Medicaid arise from a variety of causes. There have been so many changes and new directives during the three years of its operation that no physician is likely to keep accurately informed on them all. If a computer profile of the complete operation of every participating physician were carefully reviewed, (which is well nigh impossible) we would all be found

guilty of some irregularities, inconsistencies and violations, because it has been practically impossible to keep completely informed of all changes. It is apparent that some physicians have made very loose and free interpretations of the rules and have not hesitated to bend them to their own financial advantage without admitting to themselves that this must constitute acts of infringement and even plain dishonesty. They have tended to cover their deception with the cloak of ignorance. And then there appear to be indications of some willful and flagrant violations, apparently with the intent of monetary advantage. Where violations are clearly defined the physician tends to prefer restitution rather than harsher discipline.

It will require continued and constant vigilance on the part of all concerned to put and keep our house in order, and this we must do. A first step has been a letter directed to all physicians from Mrs. Milton S. Thompson Jr. Director of the Medical Assistance Program, describing in detail policies to be implemented on July 1, 1969. This is a clear and simple statement of most of the rules governing Medicaid operation in its present state and covers many of the points where violations have most frequently been found. Every participating physician should keep it in ready access for reference. The Department of Health has promised to provide other simplified statements of any changes in policy or regulations, as they are adopted, for the more effective and economical operation of the program.

In recent months we have been given some very unfavorable publicity because of our alleged mishandling of the provisions for medical care to the poor. It has by no means been well deserved criticism though based on a modicum of truth. We must, however, be intelligently responsive and maintain above reproach the traditions of the medical profession in the performance of our trust.

SAM A. OVERSTREET, M. D.

MAKE PLANS NOW

To Attend the

KMA ANNUAL MEETING

SEPTEMBER 23-25

Convention Center, Louisville



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

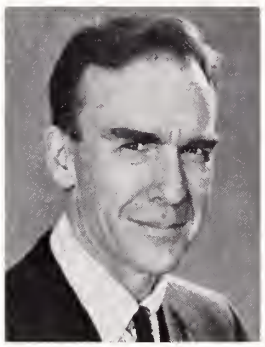
ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

ORGANIZATION SECTION

Prominent National Authorities To Join Kentucky Physicians In Timely Discussions at Annual Meeting, Sept. 23-25

Well-known medical authorities from throughout the country will join Kentucky physicians in five panel



Doctor Grissom



Doctor Geer

discussions of timely subjects during the Annual Meeting of the Kentucky Medical Association, September 23-25, at Convention Center, Louisville.

The scientific program will also feature individual presentations, a new "Cracker Barrel" Session, and the president's address. Themes for the three-day session will be "Cancer," "Drugs," "Transplants," "Obesity," "Atherosclerosis," and "School Health."

In addition to the scientific program, the meeting will include the annual convention of the Woman's Auxiliary to KMA, an Orientation Program for new members, the President's Luncheon, meetings of 16 specialty groups, the KMA House of Delegates and Board of Trustees, and scientific and technical exhibits.

Two panel discussions have been planned for the September 25 morning session of the scientific program. "New Concepts in the Management of the Patient with Atherosclerosis", moderated by Beverly T. Towery, M.D., Louisville, will be discussed by Robert L. Grissom, M.D., Omaha, Neb., Jack C. Geer, M.D., Columbus, Ohio, Marvin D. Siperstein, M.D., Dallas, Tex., and C. Thomas Flotte, M.D., Baltimore, Md.

O. B. Murphy, M.D., Lexington, will moderate the panel on "School Health, Physical Education and Medical Aspects of Sports." Discussants will be Marvin Barnett, D.M.D., Louisville, Fred Allman, Jr., M.D., Atlanta, Ga., and Allan J. Ryan, M.D., Madison, Wisc.

Doctor Grissom, guest of the Kentucky Academy of General Practice, is chairman of the department of medicine at the Universty of Nebraska. A 1941 graduate of the University of Illinois School of Medicine, he is a member of numerous medical organizations, including the Nebraska Heart Association in which he has held various offices since 1954.

The guest of the Kentucky Society of Pathologists, Doctor Geer is a 1956 graduate of the Louisiana State University Medical School and chairman of the department of pathology at Ohio State University. He has been an active member of Councils on Arteriosclerosis of the American Heart Association since 1964.

Doctor Siperstein, guest of the Kentucky Chapter, American College of Physicians, is a professor of internal medicine at the University of Texas Southwestern Medical School. A 1948 graduate of the Universi y of Minnesota Medical School he has served as a consultant to the U. S. Public Health Service and on the editorial board of many medical publications.

The guest of the Kentucky Orthopaedic Society, Doctor Allman is associated with the Atlanta Orthopedic Clinic and serves as president of the American



Doctor Siperstein



Doctor Allman

College of Sports Medicine. A 1955 graduate of the Medical College of Georgia, he received graduate training at the Tulane University Medical School. He is the recipient of many awards for his work in physical fitness programs.

All Kentucky physicians are urged by Henry B. Asman, M.D., Louisville, KMA president, to make plans now to attend what promises to be an exciting and informative meeting.

County Society Elects Dr. Coe

The Jefferson County Medical Society named Walter S. Coe, M.D., Louisville, president-elect at a recent meeting. Doctor Coe has served as editor of *The*

Journal since 1966 and is a past president of the Kentucky, Louisville and Jefferson County Heart Associations and the Kentucky Society of Internal Medicine.

Scientific Program Outline Released for Annual Mtg.

The following preliminary scientific program for the 1969 KMA Annual Meeting was released at press time by KMA President Henry B. Asman, M.D., Louisville. Each half-day session of the three-day program will feature a 30-minute intermission in order that physicians may visit the scientific and technical exhibits. The program will be presented at Convention Center, Louisville.

TUESDAY, SEPTEMBER 23

Morning Session

THEME: "Cancer"

Opening Ceremonies

"The Early Diagnosis of Cancer"—panel discussion
Benjamin F. Rush, M.D., Lexington, Moderator
Gilbert S. Campbell, M.D., Little Rock, Ark.
Richard K. Winkelmann, M.D., Rochester, Minn.
William Christopherson, M.D., Louisville
Willet F. Whitmore, Jr., M.D., New York, N.Y.

"New Trends in Chemotherapy"—panel discussion
Benjamin F. Rush, M.D., Moderator
Richard K. Winkelmann, M.D.
M. Eugene Lahey, M.D., Salt Lake City, Utah
Ricardo Fuste, M.D., Memphis, Tenn.
Willet F. Whitmore, Jr., M.D.

President's Address

Afternoon Session

Eight of the 16 participating specialty groups will meet at 2 p.m. There will be no general scientific session at this time.

WEDNESDAY, SEPTEMBER 24

Morning Session

THEMES: "Symposium on Drugs"
"Transplants"

Warren H. Pearse, M.D., Omaha, Neb.—*"Steroid Replacement Therapy"*

Alan P. Winnie, M.D., Chicago, Ill.—*"The Rational Basis for Beta-Blockades for the Treatment of Arrhythmias"*

Sidney Cohen, M.D., Chevy Chase, Md.—*"The Current Status of Drug Abuse"*

Allan M. Lansing, M.D., Louisville—*"Cardiac Transplants"*

Israel Penn, M.D., Denver, Col.—*"Liver Transplants"*

Scientific Exhibit Award Presentation

Afternoon Session

THEME: "Obesity"

"Obesity"—panel discussion
George W. Pedigo, M.D., Louisville Moderator
John C. Duffy, M.D., Armonk, N.Y.
Earl E. Vastbinder, M.D., Lexington
John S. Llewellen, M.D., Louisville

"Cracker Barrel" Session

THURSDAY, SEPTEMBER 25

Morning Session

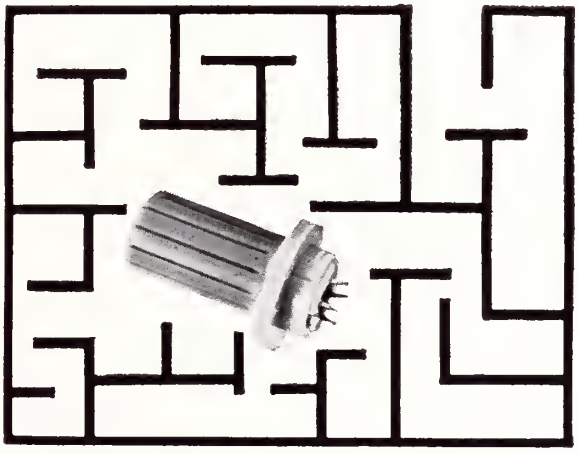
THEMES: "Atherosclerosis"
"School Health"

"New Concepts in the Management of the Patient with Atherosclerosis"—panel discussion
Beverly T. Towery, M.D., Louisville, Moderator
Robert L. Grissom, M.D., Omaha, Neb.
Jack C. Geer, M.D., Columbus, Ohio
Marvin D. Siperstein, M.D., Ph.D., Dallas, Tex.
C. Thomas Flotte, M.D., Baltimore, Md.

"School Health, Physicial Education and Medical Aspects of Sports"—panel discussion
O. B. Murphy, M.D., Lexington, Moderator
Marvin Barnett, D.M.D., Louisville
Fred Allman, Jr., M.D., Atlanta, Ga.
Allan J. Ryan, M.D., Madison, Wisc.

Afternoon Session

The remaining eight specialty groups will meet at 2 p.m. No general session is scheduled at this time.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G.I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

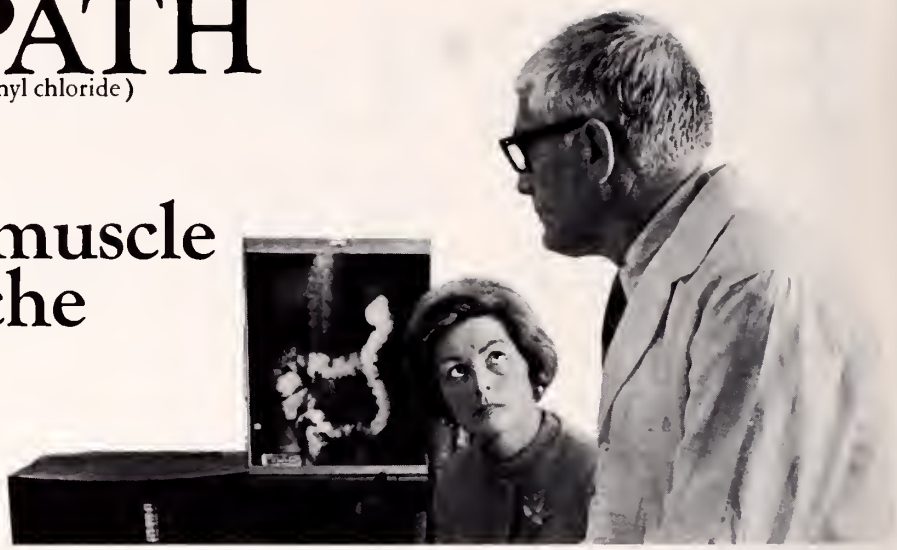
relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

Supplied

In two strengths:

'Milpath'-400: Yellow, scored tablets.

'Milpath'-200: Yellow, coated tablets.

Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)

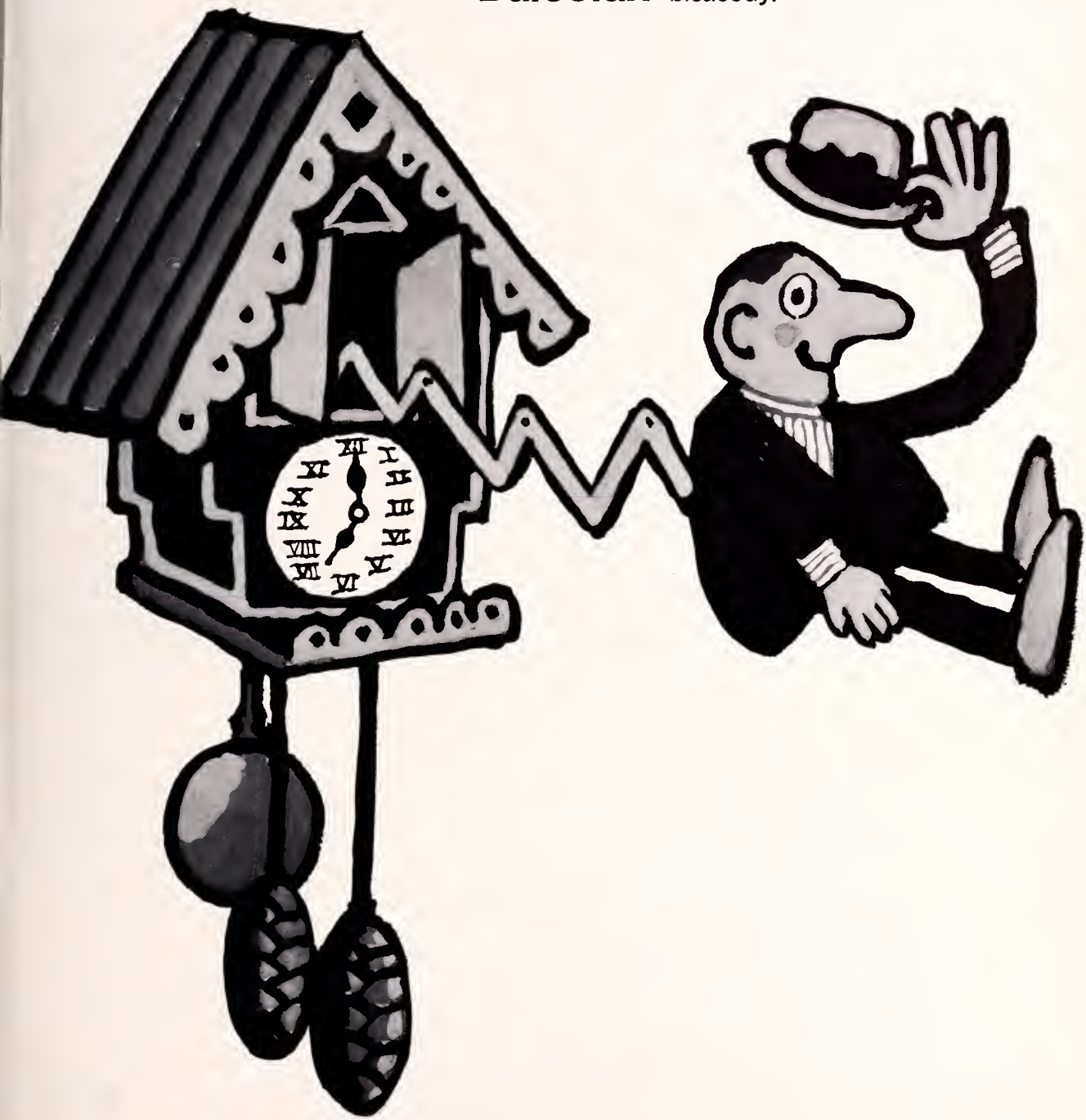
Dulcolax...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



DER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681



Clues to PVD The geriatric smoker

In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.[1]

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.[1,2] Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with *marked* peripheral vascular disease,[3] changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. *Smoking is not permissible in any stage of the disease*, since even "... minimal reduction in blood flow in patients with ischemic limbs may produce a further reduction in tissue nutrition, and thu may be another case of the proverbial straw on th camel's back."[3]

In another study of patients with peripheral vascula disease,[4] the investigators stress that decreased skin bloo flow during smoking "... is the factor of most importanc to the patient with peripheral vascular disease." *Whil such patients may adjust to the discomfort of vascular in sufficiency in skeletal muscle, decreased skin blood flow ma often lead to severe symptomatology.*

More and more physicians have adopted the practic of investigating for peripheral vascular disorder whe confronted with a geriatric patient who is a habitua smoker. Once a diagnosis is established, therapeuti measures are directed toward increasing the periphera circulation and appropriate management of the patient' general medical needs. These include the importan safeguards of keeping warm and refraining from smoking

Professional model posed for illustration.

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.
Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.
Selectivity of action—relaxes the musculature of peripheral blood vessels.
High degree of safety—side effects seldom require discontinuation of therapy.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.
Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.
Dosage: 1 or 2 Timespan Tablets morning and night.
How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

References: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., eds.: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: Proc. Med. Sect. Amer. Life Convention *51*:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. Sci. 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



Kentucky Surgeons Elect Dr. Clardy, Dr. Ray

At the first joint meeting of the Kentucky Chapter, American College of Surgeons and the Kentucky



Doctor Clardy



Doctor Ray

Surgical Society, Delmas M. Clardy, M.D., Hopkinsville, and Edward H. Ray, M.D., Lexington, were named presidents-elect of the two groups respectively. Each has served as president of the other organization—Doctor Ray in 1961-62 and Doctor Clardy in 1963-64.

Held May 16 and 17 at the Holiday Inn, Somerset, the joint session featured talks on breast cancer by Richard S. Handley, senior surgeon at Middlesex Hospital, London, England and a widely recognized authority on the subject.

Coleman C. Johnston, M.D., Lexington, was installed as president of the Chapter at the meeting and Blaire Lewis, M.D., Louisville, assumed presidency of the Society. Rudolf J. Noer, M.D., Louisville, Richard H. Weddle, M.D., Somerset and John Dickinson, M.D., Glasgow, were named to the Society's Council. John S. Sprague, M.D., Lexington, continues in the office of Society secretary.

Doctor Clardy, a 1932 graduate of the University of Louisville School of Medicine, has practiced in Hopkinsville since 1934. He was president of KMA in 1964-65, served as its treasurer from 1958-63, and was a member of the KMA House and numerous Association committees for many years. He is a trustee on the Board of the Rural Kentucky Medical Scholarship Fund.

In addition to his participation in KMA activities, Doctor Clardy has been active in both local and national medical organizations. He is a past president and secretary of the Christian County Medical Society, a consultant to the Selective Service System, and has held membership on the local board of the American Cancer Society. A fellow of the American College of Surgeons, he is a member of the Southeastern Surgical Congress and the Southern Medical Association.

Doctor Ray continues in the private practice of urology, following his retirement last month from the University of Kentucky faculty as professor of surgery in the College of Medicine. From 1963-1968 he served as professor and chairman of the College's division of urology. He has been a member of the faculty of the University of Louisville School of Medicine since 1953, serving as clinical professor of urology since 1964.

Doctor Ray holds membership in many medical organizations including the American College of Surgeons, Southern Surgical Association, and Kentucky Urological Society. In addition, he served as chairman of the Advisory Committee on Medical Education in Kentucky in 1953 and has been second vice-president of the Kentucky Civil War Roundtable since 1965.

All 15 KMA Trustee Districts Hold Meetings in 1968-1969

For the first time since KMA Trustee District meetings have been held, all 15 districts met during this 1968-69 Associational year. The Sixth District had the final meeting of the year June 26 at the Holiday Inn, Glasgow.

KMA President Henry B. Asman, M.D., Louisville, was the featured speaker at each of the 15 meetings. Doctor Aman discussed Association activities in a carefully prepared color slide presentation. A KEMPAC officer or member also made a brief presentation of that organization's activities at each meeting.

Doctor Asman expresses his appreciation to the 15 trustees and the physicians in their districts who planned and attended the meetings.



KMA President Henry B. Asman, M.D., Louisville, arrives at the Holiday Inn, Ashland, to speak at the annual meeting of the Thirteenth Trustee District May 28. Doctor Asman presented a slide program depicting Association activities at each of the 15 trustee district meetings this year.

KMA Washington Dinner Hosts All Ky.'s U. S. Congressmen

The Twelfth Annual KMA Washington Dinner honoring the state's U.S. senators and representatives was attended by all nine of Kentucky's congressmen May 13 at the Mayflower Hotel.

A total of 67 persons, including the congressmen's wives, administrative assistants, their spouses and KMA members, attended the event. KMA was represented by officers, members of the Committee on Legislative Activities, congressional keymen, KEMPAC directors, Woman's Auxiliary members and staff.

In addition to the dinner, the day's activities included a briefing breakfast attended by physicians and their wives, representatives of the AMA Washington office, a representative of Kentucky Blue Shield and KMA staff, and visits to the senators and representatives' offices.

KEMPAC Invites U. S. Congressmen To Speak at Annual Seminar

Senator Edmund S. Muskie (D), Waterville, Maine, and Representative Rogers C. B. Morton (R), Easton, Md., have tentatively accepted KEMPAC's invitation to speak at its annual seminar, according to John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board.

The seminar, including a social hour, dinner, and the program, will begin at 6 p.m., September 22, in the Terrace Room of the Kentucky Hotel, the evening preceding the Annual Meeting of the Kentucky Medical Association. A member of AMPAC will also appear on the seminar program.

Doctor Quertermous has been advised that the two congressmen will be present unless a conflict arises precluding their attendance. They have been asked to discuss the importance of physician participation in the affairs of government and politics.

Senator Muskie has served in the U.S. Senate since January, 1959, following a four-year term as governor of Maine. Representative Morton, a Kentucky native, has represented Maryland's First District in the U.S. House since 1963.

Eighteen-Member Ky. Delegation Attends AMA/AMPAC Seminar

A Kentucky delegation of 18 members attended the AMA/AMPAC public affairs seminar May 16-18 in Washington, D.C.

A number of prominent figures from the U.S. Senate, House of Representatives and various governmental departments appeared on the program. Representative Gerald Ford, Michigan, Senator Jennings Randolph, West Virginia, Senator Howard H. Baker, Jr., Tennessee and Creed C. Black of the Department of Health, Education and Welfare were among the speakers who presented a wealth of information on programs and legislation that will be of interest in the years ahead.

The Kentucky delegation included Lee C. Hess, M.D., chairman of the KMA Board of Trustees; Walter L. Cawood, M.D., KMA president-elect; Hoyt D. Gardner, M.D., national affairs chairman for the KMA Committee on Legislative Activities, and Mrs. Gardner, president-elect of the Woman's Auxiliary to KMA; Fred C. Rainey, M.D., state affairs chairman for the KMA Committee on Legislative Activities; John C. Quertermous, M.D., chairman of the KEMPAC Board; C. Kenneth Peters, M.D., secretary-treasurer of KEMPAC, and Mrs. Peters; Robert Long, M.D., AMA trustee; R. Burke Casper, M.D. KEMPAC director; John Stewart, M.D., KEMPAC director; Meredith J. Evans, M.D., KEMPAC director, and Mrs. Evans; David A. Hull, M.D., member of KMA Committee on Legislative Activities; Carl Scott, M.D.; Mrs. Barbara Rice, executive secretary of the Fayette County Medical Society; Gilbert L. Armstrong, KMA director of field services; and Jerry E. Mahoney, KMA assistant director of field services.



John T. Alexander, Marrowbone (left), accepts a plaque presented to him by J. Ed McConnell (center), and Oscar Miller, M.D., commemorating his enrollment as the one-millionth member of Kentucky Blue Shield.

One-Millionth Member Enrolls In Kentucky Blue Shield

Kentucky Blue Shield enrolled its one-millionth member recently, according to J. Ed McConnell, Louisville, president of Kentucky Blue Cross and Blue Shield. In making the announcement, Mr. McConnell expressed pride in the event occurring during Blue Shield's 20th anniversary year.

John T. Alexander, Marrowbone, the one-millionth member, enrolled in the Blue Cross and Blue Shield College Student Program at the University of Kentucky when he reached age 19 and was no longer covered under his parents' contract.

Oscar Miller, M.D., recognized as the Father of Kentucky Blue Shield and an original member of its Board of Directors, and Mr. McConnell presented a plaque to Mr. Alexander commemorating the event.

KSAMA Holds Seventh Convention May 16-18 at Elizabethtown

The Seventh Annual Convention of the Kentucky State Association of Medical Assistants May 16-18 in Elizabethtown was attended by 105 medical assistants from throughout the state. Outgoing president, Mrs. Jane Burks, Elizabethtown, presided at the meeting.

Guest speakers appearing on the program included Henry B. Asman, M.D., Louisville, KMA president, and Fred C. Rainey, M.D., Elizabethtown. Guests included Mrs. Elvira Fischer, Chicago, Ill., and Mrs. Betty Fisher, Evansville, Ind., past presidents of the American Association of Medical Assistants, and Mrs. Jo Ann Hutchens, immediate past president of the Tennessee Medical Assistants.

The Association presented a special merit award to James Pleasant, Madisonville, who became the first certified medical assistant in Kentucky recently. Mr. Pleasant serves as president of the Hopkins County Medical Assistants Association.

New officers installed by Miss Dorothy Downs include Mrs. Mabel Ann Veech, president-elect; Miss Libby Curtsinger, president; Mrs. Faye Jordan, vice president; Mrs. Thelma Hemmerle, secretary; and Miss Gerry Schutz, treasurer. All are from Louisville.

Mrs. Veech, a medical assistant for 17 years, has served KSAMA as its vice president and 1968 convention chairman. She is a past president and vice president of the Jefferson County Medical Assistants.

In Memoriam

MORRIS FLEXNER, M.D.
Louisville
1890-1969

Morris Flexner, M.D., 79, a Louisville internist, died June 3 at Norton Memorial Infirmary. A 1914 graduate of Johns Hopkins University School of Medicine, Doctor Flexner had practiced in Louisville since that time. He was a fellow of the American College of Physicians, a clinical professor of medicine at the University of Louisville School of Medicine, and the author of numerous medical publications.

JAMES S. RICH, M.D.
Lexington
1905-1969

James S. Rich, M.D., 63, a Lexington radiologist, died suddenly May 30 at Leitchfield while enroute to Evansville. Doctor Rich graduated from Rush Medical College in 1932 and had practiced in Lexington since 1947. A former president of the Fayette County Cancer Society, Doctor Rich held membership in the American College of Radiology and the Radiological Society of North America.

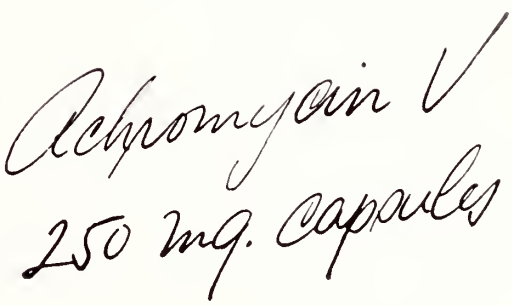
Scholarship Fund Grants Loans To 35 Medical Students

Loans to 10 first-year medical students and 25 upperclassmen, totaling $74,500 were approved by the Board of Trustees of the Rural Kentucky Medical Scholarship Fund at its annual meeting May 22, according to C. C. Howard, M.D., Glasgow, Board chairman.

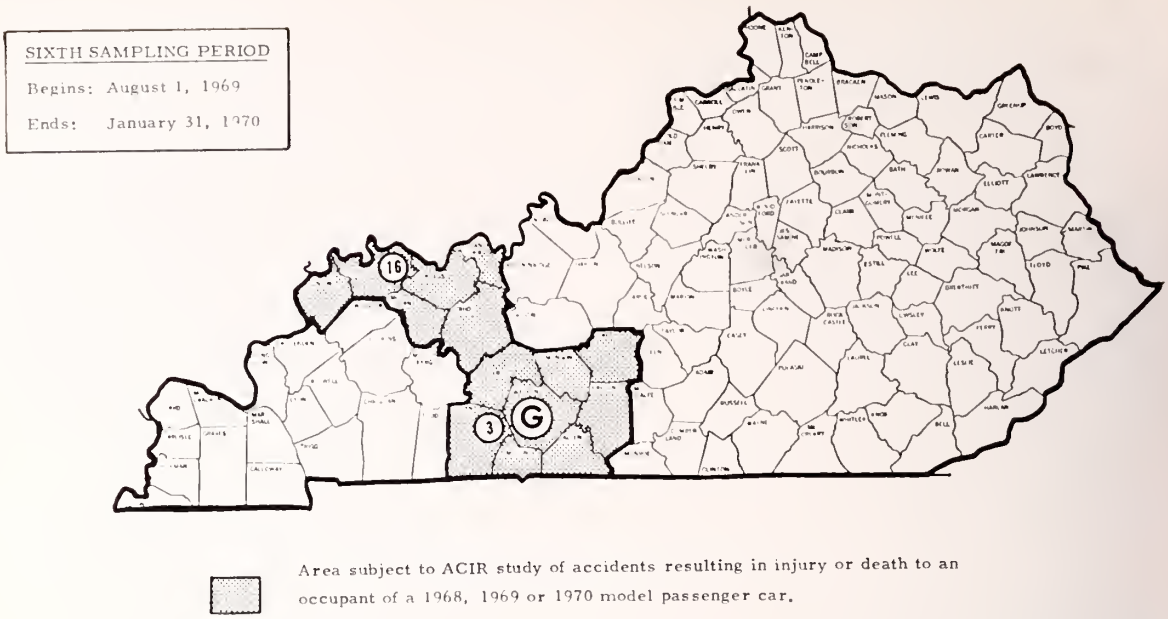
Twenty-one of the recipients have agreed to practice in "critical" counties following their medical training. Billie J. Caudill, M.D., Morehead, and Donald Chatham, M.D., Shelbyville, previous scholarship recipients of the Fund, were elected to the Fund's Board of Trustees.

Recipients of freshman-year loans are Lawrence Brock, Columbia; Kenneth E. Embry III, Leitchfield; James A. Freer, Fordsville; Virginia L. Garner, Jamestown; Thurman D. McKinney, Quality; Larry Michael Mason, Richmond; Michael A. Pfeifer, Louisville; Charles Van Meter, Jr., Leitchfield; Charles F. Winkler, Central City; and Robert W. Young, Harrodsburg.

At the meeting Doctor Howard expressed the appreciation of the Board for the support and interest of Governor Louie B. Nunn, Health Commissioner Russell E. Teague, M.D. and the Kentucky General Assembly.



ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481D-9



Sixth Auto Crash Study Phase To Begin August 1 in Ky.

The sixth study phase of the Kentucky-Cornell Automotive Crash Injury Research Program (ACIR) will being August 1 in 14 Kentucky counties. The program's purpose is to determine causes of injuries sustained in crashes of late model passenger cars with the ultimate goal of making automobiles safer.

Physicians in the participating counties may be asked to assist in the program by filling out forms concerning injuries or deaths of occupants in cars involved in accidents. KMA Highway Safety Committee Chairman William K. Keller, M.D., Louisville, urges the cooperation of all physicians in the program.

Counties in which the sixth study will be conducted from August 1, 1969 to January 31, 1970, include Allen, Barren, Butler, Daviess, Edmonson, Hancock, Hart, Henderson, Logan, McLean, Ohio, Simpson, Union and Warren.

The program is sponsored by KMA, the Kentucky State Department of Health, the Kentucky Hospital Association, and the Kentucky State Police in cooperation with Cornell University where the research information is compiled and studied.

Whiplash Abdominal Injury

(Continued from page 503)

2. Spalteholz, W., *Hand-Atlas of Human Anatomy,* Vol. III: J. B. Lippincott Co., Philadelphia and London, p. 563.
3. *Ibid,* p. 442.
4. Jordan, J.S., McAfee, D.K., Wounds of the jejunum and ileum. *Am. Surgeon 29:* 630, 1963.
5. Ballinger, *op. cit.,* p. 354.
6. Moseley, H.F., *Accident Surgery,* Vol. I: Appleton-Century-Crofts, New York, 1962, Chapter XII, p. 131.

Police, Fire Surgeons Society

The American Medical Association has appointed an ad hoc committee to establish a national society of Police and Fire surgeons. Any physician interested in membership in the society is invited to contact Howard Schneider, M.D., National Association of Police and Fire Surgeons, 75 Lee Avenue, Yonkers, N.Y. 10705

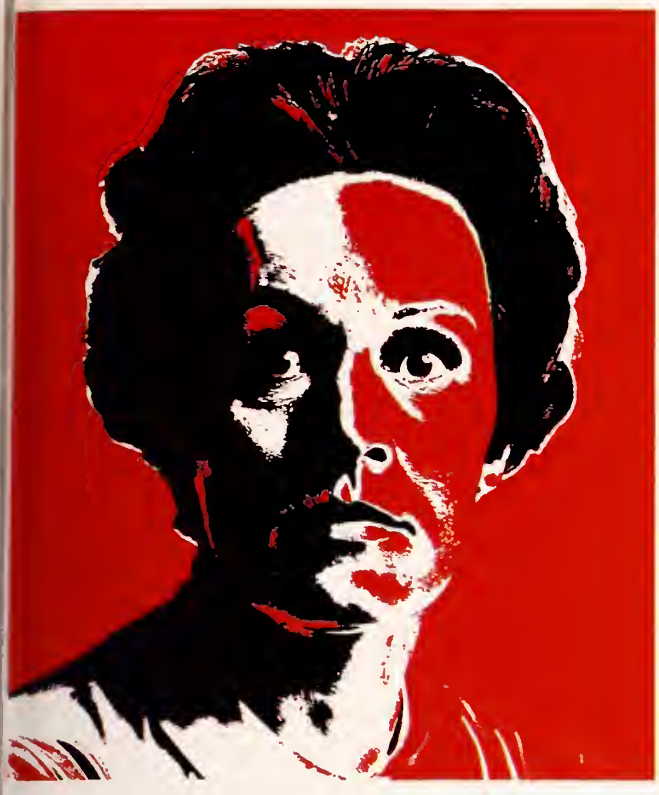
Papers on Air Pollution Sought

Papers on air pollution are being sought for presentation at the December, 1970 Conference of the International Union of Air Pollution Prevention Associations in Washington, D.C. Physicians interested in submitting such a paper should contact Prof. Arthur C. Stern, Department of Environmental Sciences and Engineering, School of Public Health, University of North Carolina, P.O. Box 630, Chapel Hill, N.C. 27514.

Infant Air Transport System

An emergency air-ground transport system for rushing newborn infants with Respiratory Distress Syndrome to special ventilating equipment has been established by the Virginia Polytechnic Institute, Blacksburg, Va. An airplane equipped with special respiratory support equipment transports the infants to the Roanoke, Va. Memorial Hospitals at no charge to patient or physician. The transport service will remain in operation until the special equipment at the hospitals becomes available commercially.

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray



When pollens fly, just one or two squirts of NTZ in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTZ helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1%, antihistamine
Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTZ should be repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (1289-M

Winthrop

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

now she can cope...



thanks to

Butisol SODIUM®

(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

KMA Committee Reports

Educational Television Committee

William P. VonderHaar, M.D., Louisville, Chairman

University of Kentucky **April 30, 1969**
Lexington, Kentucky

Members of the Educational Television Committee met on April 30 in Lexington, to discuss further plans for sponsoring a number of continuing medical education programs over the Kentucky Educational Television Network. The first series of programs will feature four short films on various medical topics, followed by a longer film on some aspect of cancer.

Plans for promoting the programs were also discussed. The committee also anticipates a follow-up survey of Kentucky physicians to determine their interest in ETV as a mechanism for continuing medical education.

KMA-KNA Joint Advisory Committee

A. Evan Overstreet, M.D., Louisville, Chairman

KMA Headquarters Office **May 15, 1969**

The Joint Advisory Committee of the Kentucky Medical Association and Kentucky Nurses' Association met recently and discussed plans for increasing liaison between those organizations. The committee also heard a report on the AMA Committee on Nursing's Second Annual Conference from A. Evan Overstreet, M.D., the physician chairman, who had attended the conference in April.

A number of joint policy statements were discussed and were forwarded to the governing bodies of both Associations for consideration. Other items of discussion included the role of a registered nurse as first assistant in an operating room, and Comprehensive Health Planning.

Coordinating Commission on Governmental Medical Services

Paul J. Parks, M.D., Bowling Green, Chairman

KMA Headquarters Office **May 21, 1969**

The Coordinating Commission on Governmental Medical Services held its first meeting of the Associational year on May 21, 1969, at which time progress reports were given by the chairmen of the Committee on Appalachian and OEO Programs, the newly formed Claims Review Committee, the Committee on Medical Education, and both the Advisory Committee on Title XVIII and the Technical Advisory Committee on Physician Services (Title XIX).

Advisory Committee on Title XVIII (PL 89-97)

Paul J. Parks, M.D., Bowling Green, Chairman

KMA Headquarters Office **May 21, 1969**

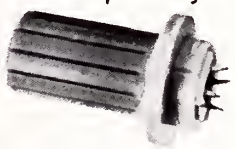
The KMA Advisory Committee on Title XVIII met at the Association Headquarters to take up several matters of vital importance which included the following: The Federal Government's interest in cost reduction of the Medicare Program. Representatives of Blue Cross—Blue Shield discussed at length the problems and misunderstandings which have arisen concerning custodial versus needed medical care in Extended Care Facilities.

Representatives of Metropolitan Life Insurance Company reviewed their activity regarding Medicare. A discussion of a "freeze" by the Federal Government on customary charges was held and the members of this committee were informed that physicians should continue to report their customary charges.

A further meeting will be held in Lexington, June 11 to discuss problems regarding utilization of the Medicare Program.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochloride

In depression...
when words are not enough

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

Pertofrane® desipramine hydrochloride

Indications: For relief of depression.

Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.

Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.

Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.

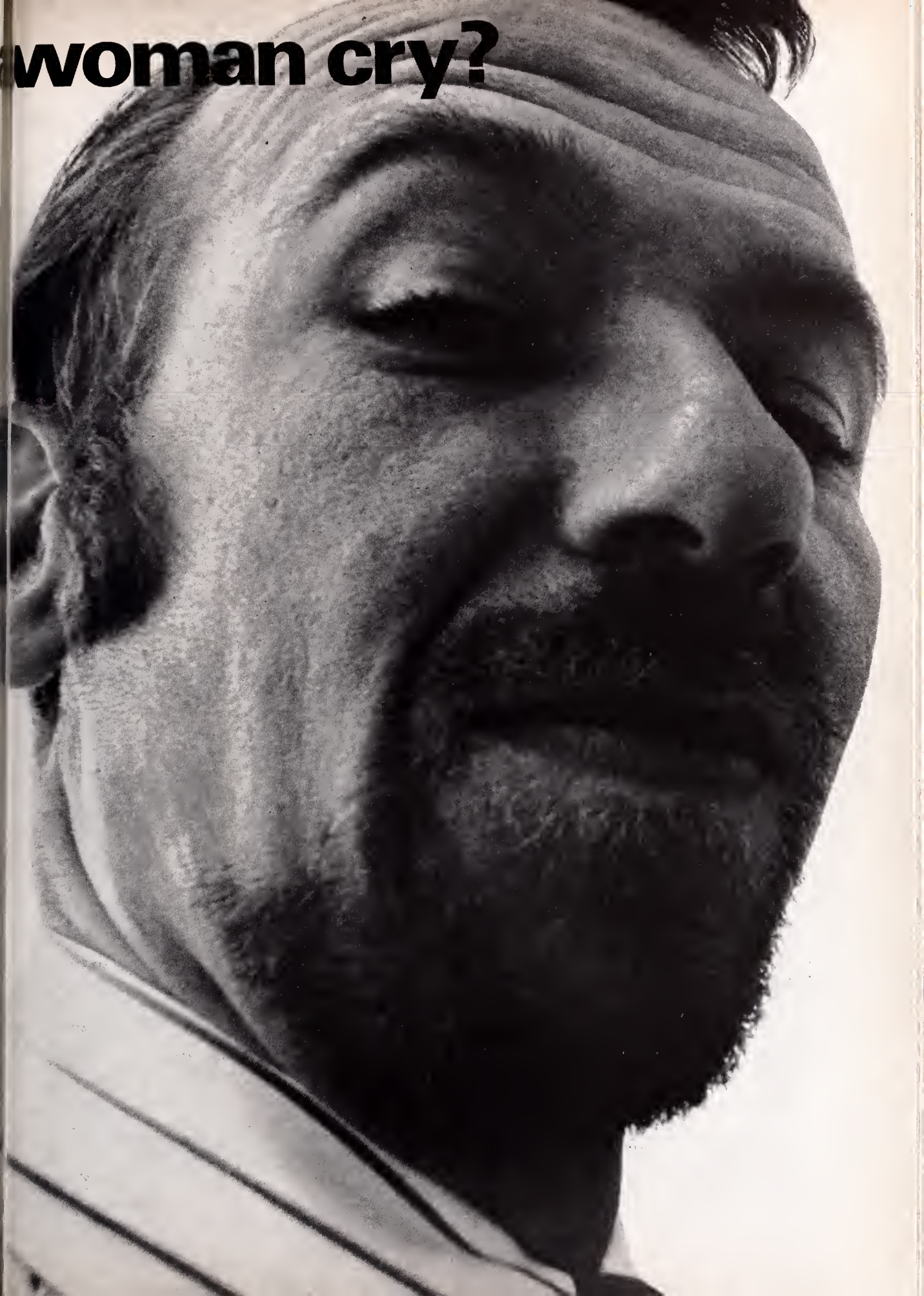
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.

Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

woman cry?



KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665 President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660 Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123 Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661 Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211 Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282 Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 .. Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 .. Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362 .. 1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525 .. 1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231 1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406 1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751 1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155 1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616 .. 1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357 1969

Buyers Guide

JULY BUYERS GUIDE FOR JOURNAL OF KMA 1969

Bristol Laboratories 483
Burroughs Wellcome 472
Business & Professional Adjustment Service, Inc. 477

Campbell Soup S0S

Geigy Pharmaceuticals 474-476, S21, S34-S3S
General Leasing Corporation 48S
Glenbrook Laboratories S24

Highland Hospital 480
Hynson, Westcott & Dunning 461

Lederle Laboratories 463, 477, S17, S27, S31, S33, S37
Lilly, Eli & Company 490

McNeil Laboratories S32
Medical Protective Company S37

National Drug Company 460, 487-488

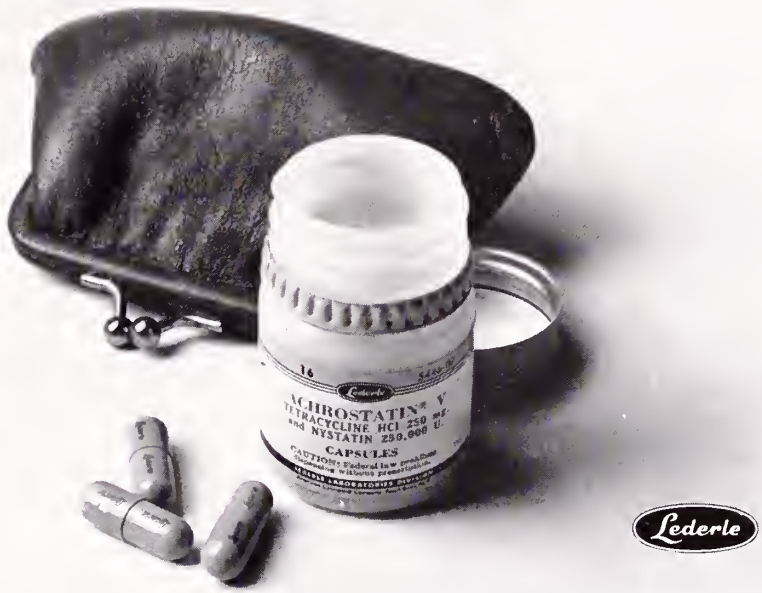
Parke, Davis Company S08

Riker Laboratories 466-467
Robins, A. H. Company 489
Roche Laboratories 469-471, 484-48S, S22-S23, S38
Rorer, Wm. H. Company 479

Sandoz S29
Searle, G. D. & Company S06-S07
Southern Optical Company 480

Wallace Pharmaceuticals S18-S20
Warner-Chilcott 481-482
Winthrop Laboratories S30
Wyeth Laboratories S09-S10, S1S

—The lowest priced tetracycline—nystatin combination available—



★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

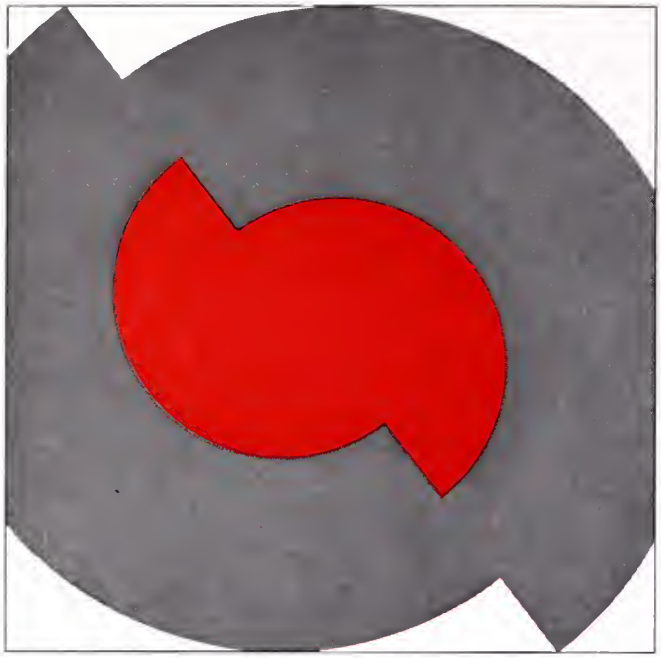
THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuatian of the drug and similar to those seen with barbiturates, have been reparted. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

VOLUME 67 AUGUST 1969 NUMBER 8

The Journal of The KENTUCKY Medical Association

Annual Meeting Issue



LIBRARY OF THE
COLLEGE OF PHYSICIANS
AUG 21

In This Issue

Cancer Chemotherapy
J. W. Yarbro, M.D., Ph.D. 565

A Familial Microepidemic of Histoplasmosis
Kenneth S. Welsh, M.D., Ibrahim Ildirim, M.D. and Michael L. Furcolow, M.D. 569

Tracheobronchial and Esophageal Foreign Body Extraction in Infants and Children
Edwin Nighbert, M.D., Robert Combs, M.D. and J. Kent Trinkle, M.D., F.A.C.S. 573

Special Article

More on Medicare and Medicaid 582

KMA Annual Meeting Section 593

Complete Contents on page 542



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, on additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-919A U.S. PATENT NO. 3,001,910 5/59

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

Volume 67 • August 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Diane Maxey

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussians
William W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1972
Richard R. Crutcher, M.D.
Chrisman S. Jackson, M.D.
E. Truman Mays, M.D.
Joseph Parker, Jr., M.D.
Elmer G. Prewitt, M.D.
Carl E. Rutledge, Jr., M.D.
Winston Rutledge, M.D.
A. Franklin White, M.D.

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D.
Roy A. Martin, M.D.
Charles R. Perry, M.D.
David C. Shipp, M.D.
John H. Willard, M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Cancer Chemotherapy
J. W. Yarbo, M.D., Ph.D 565

A Familial Microepidemic of Histoplasmosis
Kenneth S. Welsh, M.D., Ibrahim Ildirim, M.D. and Michael L. Furcolow, M.D. 569

Tracheobronchial and Esophageal Foreign Body Extraction in Infants and Children
Edwin Nighbert, M.D., Robert Combs, M.D. and J. Kent Trinkle, M.D., F.A.C.S. 573

SPECIAL ARTICLES

More on Medicare and Medicaid 582

EDITORIALS

1969 KMA Annual Meeting
Walter S. Coe, M.D. 587

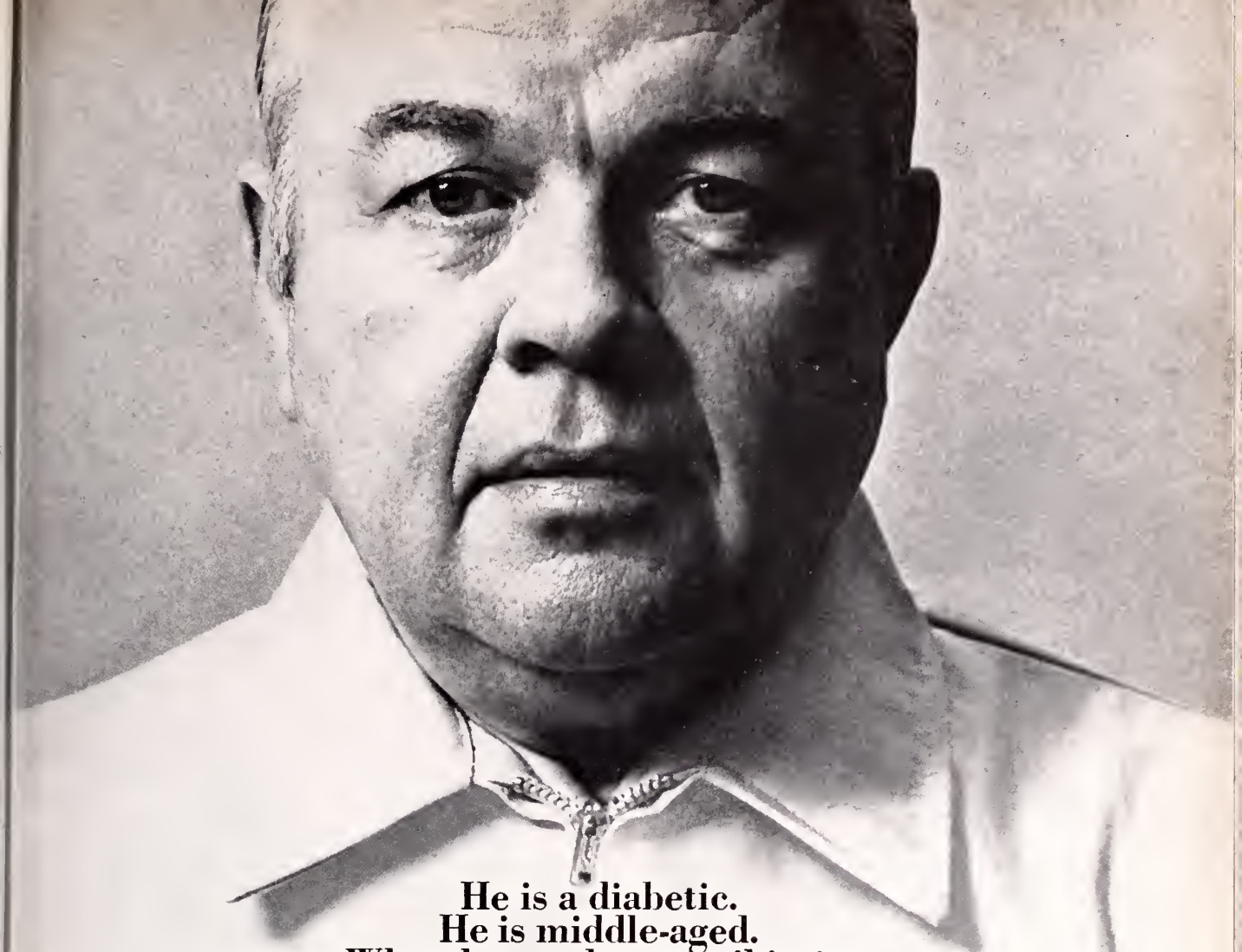
KMA ANNUAL MEETING SECTION 593

ORGANIZATION

Health Consultant Appointment Goes to Dr. Gradie Rowntree 619
Physical Fitness Award Given Ta Dr. Kelley of Somerset 619
Opportunities Available to General Practitioners Through KMA Physicians Placement Service 620

REGULAR FEATURES

President's Page 544
Insurance Page 548
Postgraduate Opportunities ..552
Maternal Mortality 558
Medical Progress 562



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

346-8

MESSAGE FROM THE PRESIDENT



Where Is Your Delegate?*

FOR a number of years we have heard the complaint from the rural and semi-rural areas of the Commonwealth that the municipalities, with their large number of delegates and ease of attendance at meetings, are forming all policy for the State Medical Society. It is my contention that while this may appear to be true, the Board of Trustees, the Executive Committee and the staff of KMA are inherently interested in the views of all of its members.

Nothing would please us more than to have 100 per cent participation of all delegates in the 1969 House, for it is here that policy for KMA is truly developed. The Board of Trustees, the Executive Committee and the staff are only the implementors of this policy. It is, therefore, the responsibility of every component society to make sure that they have named delegates who are willing to give of themselves and of their time. In addition, it is the responsibility of a society member to cover his practice so that he can attend the meeting in their behalf.

As Chairman of the Board of Trustees for this past year it has been repeatedly brought to my attention how important it is to know the views of all of the component societies. The fact that so many of the outlying societies never send their representatives to present their views makes a weak link in our Association.

I feel, and very strongly, that any man who accepts the responsibility of delegate has as much responsibility as any member of the Congress of the United States to be in his seat at the House of Delegates meeting, and for the entire session. Here decisions are made that affect him, his cohorts, his patients, his family and their livelihood.

It is my feeling, therefore, that if a delegate cannot be in his seat, or does not intend to be in his seat, he should tell his component society so that they can send someone else. For if these individuals do not come and present their views, organized medicine has lost the benefit of their experience and knowledge.

We have very little left of individual freedoms except the voice of argument and discussion and the loud, clear voice of THE VOTE. If we do not exercise this right, then we are truly giving up our greatest freedom. Make sure your delegate is at the 1969 meeting.

L. C. HESS, M.D., CHAIRMAN
BOARD OF TRUSTEES

This is the third in a series of articles written at the request of KMA President Henry B. Asman, M.D.

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

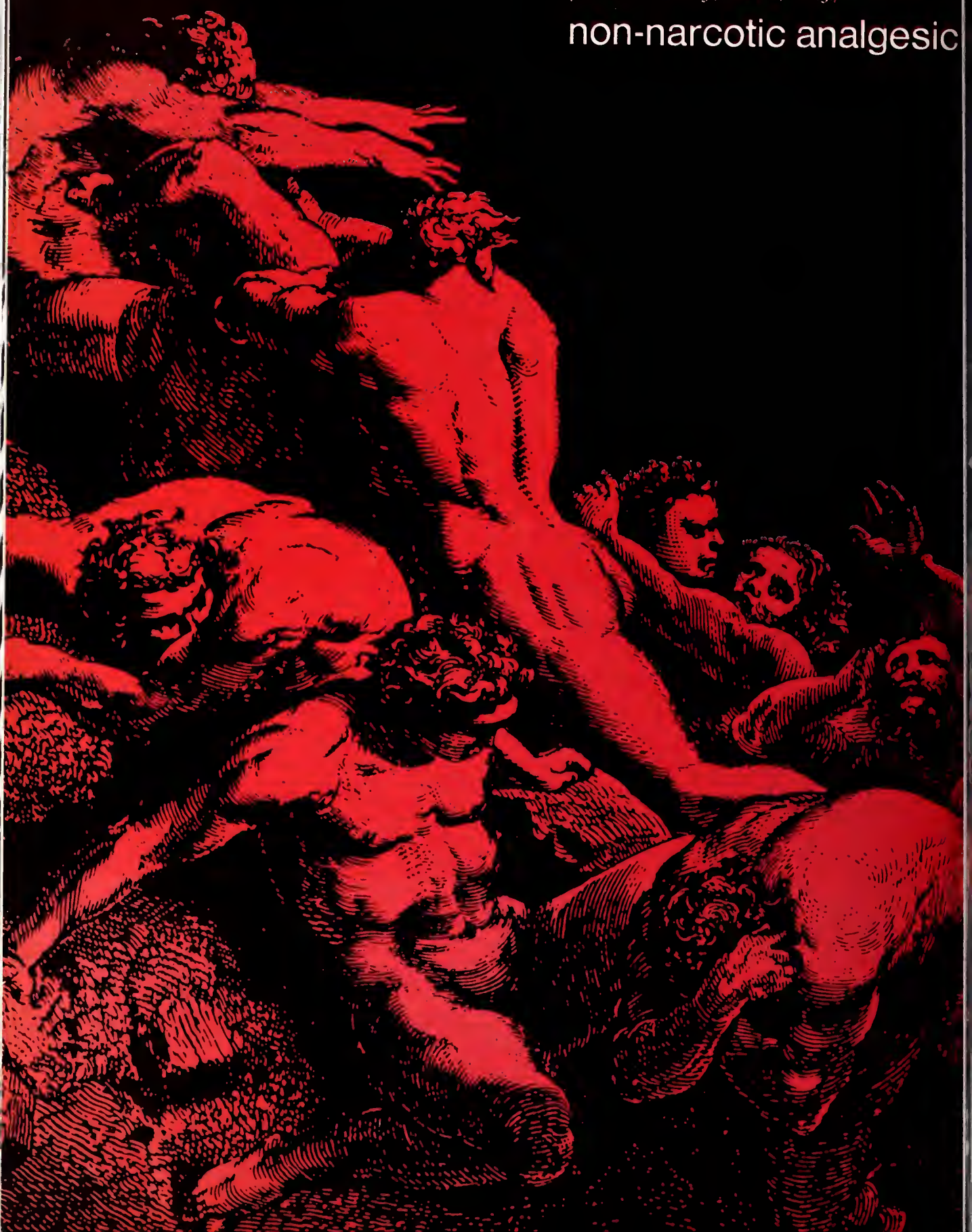
ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

NORGESIC

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesic



For musculo-skeletal pain,

try Norgesic first . . . 8 of 10 patients probably won't need anything stronger

NORGESIC offers predictable relief in approximately 80% of patients with painful musculo-skeletal disorders. It provides *both* effective analgesia and relief of associated muscle spasm. NORGESIC works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer.

For the relief of acute mild to moderate pain associated with musculo-skeletal disorders, try NORGESIC first... eight of ten patients probably won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, NORGESIC should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering NORGESIC to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

Sponsors of Riker Service—
the complimentary classified service for physicians.

Medical Economics says:

GENERAL LEASING'S PLAN IS

"The Winning Way"

TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ **Leasing better than buying**
- ★ **No capital investment**
- ★ **Dependable car at all times**
- ★ **Certain tax advantages**
- ★ **Call us for particulars**

LEASE
Medical or Surgical
EQUIPMENT

- ★ **A plan for young doctors**
- ★ **Medical and Surgical equipment**
- ★ **Complete office furnishings**
- ★ **Enlarging facilities**
- ★ **Call us for full details**

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207



THE INSURANCE PAGE



Runaway Medical Costs

The medical profession is presently undergoing a damaging barrage of criticism, with almost daily headlines from Washington charging high prices and fraudulent practices against physicians providing care to the poor and elderly under the Medicare and Medicaid programs. Government investigations have carefully teased the press and television with sample cases of dishonesty among physicians, dentists, nursing homes and hospitals. On May 14, Finance Committee member John Williams (R-Delaware) charged that "profiteers have had a field day with the program and their schemes for cheating medicare are still coming to light." Finance Committee chairman Russell B. Long (D-Louisiana) has also stirred interest in Medicare and Medicaid costs by charging on the Senate floor, that the Mafia is behind a multi-million dollar fraud involving Medicaid dental services in one state.

Thus, when the hearings of the Senate Finance Committee finally roll around later this year, they seem destined to produce daily headlines. The result could be a Congress and a public outraged by apparent evidence that the health professions are getting rich from Medicare and Medicaid while everyone else is worrying about inflation and the rising level of government spending.

Organized medicine would be well advised to take a serious view of the political consequences of what appears to the average citizen to be a runaway situation in the medical economy. There can be no question that pressure is building for Congress to put some sort of lid on medical care costs.

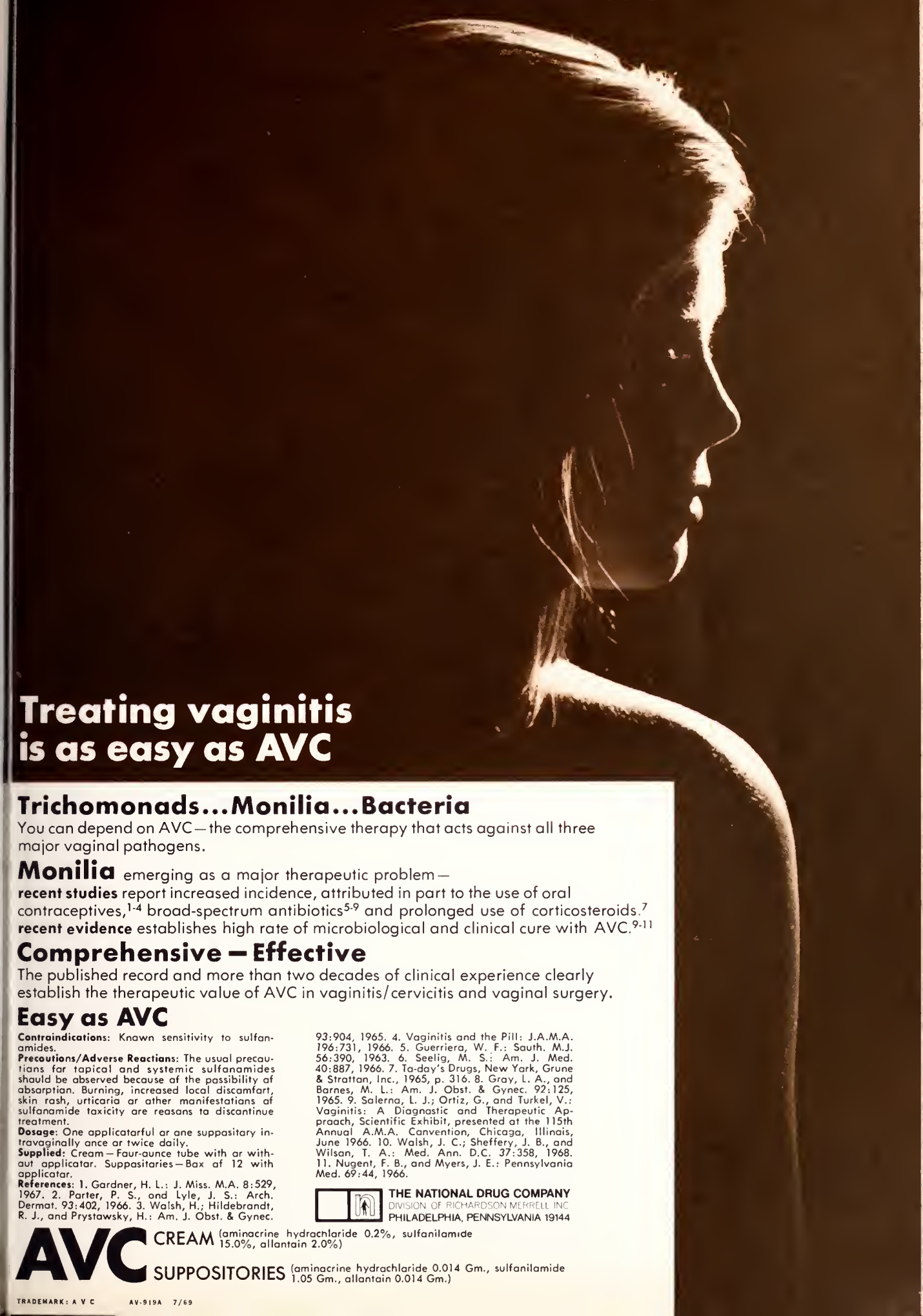
Judging by recent history of congressional investigations of health costs it appears that further hearings will do little more than rehash old problems. The breadth and complexity of the subject has proved almost overwhelming so far for committee staffs.

No one doubts the sincerity of senators and congressmen who, like many health leaders, want to do something about health care costs. But if congressional experience of the past year proves anything it is that these problems of health economics are not likely to be resolved under television lights in a Capitol Hill hearing room.,

The health team should, however, lose no opportunity to help those who make federal policies understand the realities of our present day medical economy and the historical developments that made it what it is.

New methods of organizing and delivering medical care will not in themselves stabilize costs. But it would seem sensible for the Federal government to radically refashion the Medicare package and to subject it to the same professionally devised control mechanisms that Blue Shield has evolved through decades of hardnosed negotiations with other large third party buyers, such as the steel, auto and telephone industries and their labor unions. In other words, medicine might urge, most properly and constructively, that government abandon the idea of setting up parallel, rival programs of medical care for the aged, the indigent, the disabled, etc., and instead permit those programs to be integrated into the highly successful, professionally disciplined, complex of medical prepayment and insurance mechanisms which already serve some 75 per cent of the American people.

WILLIAM W. HALL, M.D.



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrachloride 0.2%, sulfanilamide 15.0%, allantain 2.0%)

AVC SUPPOSITORIES (aminacrine hydrachloride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69

in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the theropeutic effects of trypsin in on orol form os odjunctive theropy for the ropid resolution of inflommotion ond edemo. ORENZYME BITABS is convenient to use, promotes potient cooperotion ond is ideolly suited for molntenonce theropy following porenterol trypsin.

Indications: When used os odjunctive theropy for the ropid resolution of inflommotion ond edemo, good results hove been obtolned in:

- ☐ Accidentol Troumo
- ☐ Postoperotlve Tlssue Reoctions.

Other conventionol meosures of treotment should be used os indicoted. In infection, oppropriote onti-infective theropy should be given.

Contraindications: ORENZYME BITABS should not be given to potients with o known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with coution in potients with obnormolity of the blood clotting mechonism such os hemophilio, or with severe hepotic or renol diseose. Sofe use in pregnoncy hos not been estobllshed.

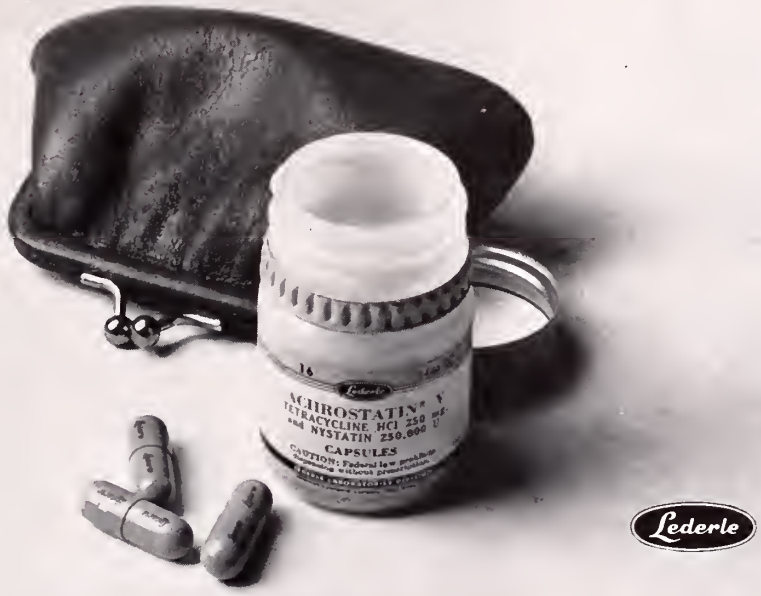
Adverse Reactions: Adverse reactions with ORENZYME hove been reported infrequently. Reports include ollergic monifestations (rosh, urticorio, itching), gostrointestinol upset ond increosed speed of dissolution of onimol-origin surgicol sutures. There hove been isoloted reports of onophylactic shock, olbuminuria and hematuria. Increased tendency to bleed hos olso been reported but, in controlled studies, it has been seen with equol incidence in placebo-treoted groups. (See Precoutions.) It is recommended thot if side effects occur medicotion be discontinued.

Dosage: One toblet q.l.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

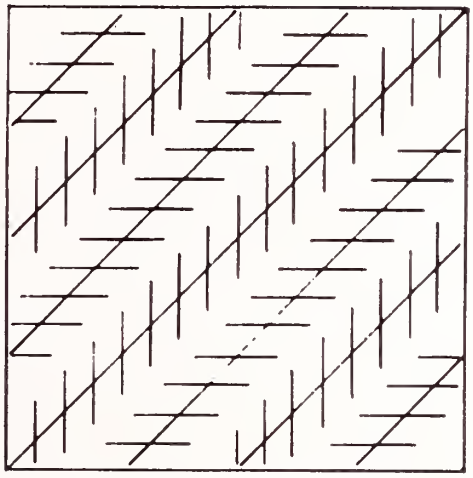
TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

–The lowest priced tetracycline–nystatin combination available–



OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

MATERNAL AND CHILD HEALTH

Postgraduate programs in the field of Maternal and Child Health will be offered by the University of California School of Public Health at Berkeley beginning in July and September, 1970. They are as follows:

"Maternal and Child Health"—nine months
"Family Planning"—nine months
"School Health"—nine months
"The Multiply Handicapped and Mentally Retarded Child"—21 months
"Career Development Programs"—36 months

For information, write to Helen M. Wallace. M.D., School of Public Health, University of California, Berkeley, California, 94720.

IN KENTUCKY

AUGUST

24 Symposium on the Common Fungus Infections for the Clinician, University of Kentucky College of Medicine and KAGP, Imperial House, Lexington

SEPTEMBER

23-25 KMA ANNUAL MEETING. Convention Center, Louisville

OCTOBER

26-30 Medical Library Association, Brown Hotel. Louisville

NOVEMBER

6-7 Third Annual Newborn Symposium, Department of Pediatrics, University of Louisville School of Medicine, Louisville

13-14 Recent Developments in the Surgical Care of Trauma Program, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

AUGUST

10-15 American Congress of Rehabilitation Medicine Annual Session, Palmer House, Chicago, Ill.

17-22 American Congress for Physical Medicine and Rehabilitation, Chicago, Ill.

18-21 American Hospital Association Annual Meeting, Chicago, Ill.

24-29 International Congress of Gerontology, Sheraton-Park and Shoreham Hotels, Washington, D.C.

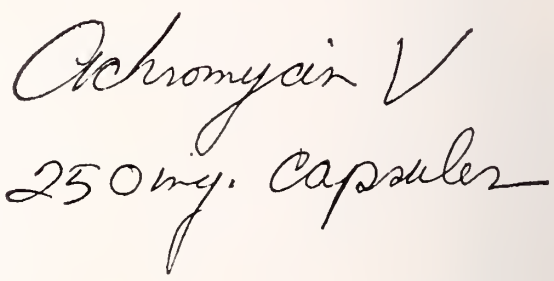
SEPTEMBER

4-6 American Association of Obstetricians and Gynecologists, Hot Springs, Va.

10-11 Pediatrics Postgraduate Conference, University of Iowa, Iowa City, Iowa

15-16 Congress on Occupational Health, American Medical Association, St. Louis, Mo.

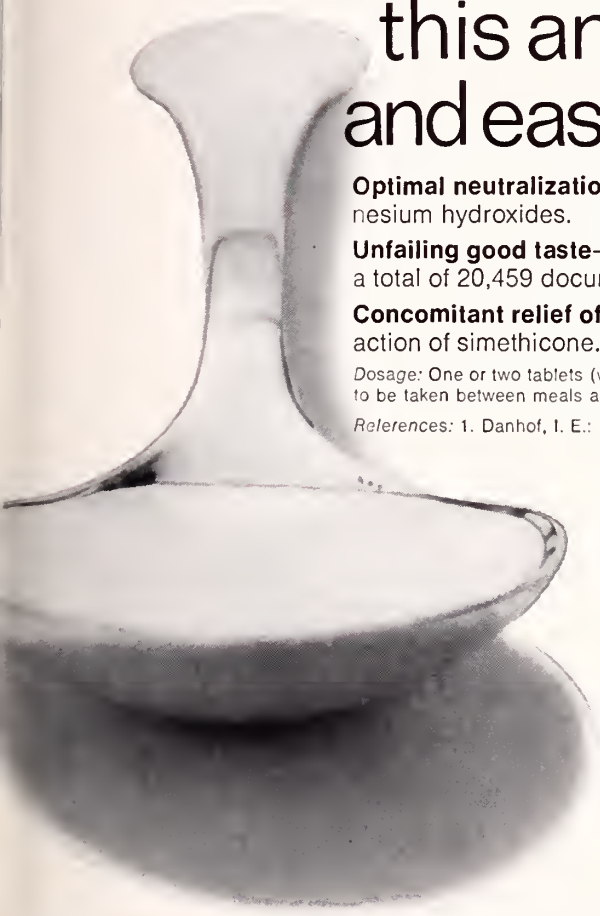
19-20 Great Plains Regional Heart Meeting, University of Iowa, Iowa City, Iowa



ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481C-9

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

at CONVENTION TIME

and THROUGHOUT THE YEAR



he KENTUCKY HOTEL

Velcomes The

ENTUCKY MEDICAL ASSOCIATION

The Kentucky Hotel takes pride in being chosen once again to serve as your HOSPITALITY HOST during your Annual Meeting September 23-25 in Louisville.

Your CONVENTION HEADQUARTERS, situated in the exciting atmosphere of Downtown Louisville, features decorative surroundings and traditionally fine service. Your stay with us will be a pleasant and memorable experience.

Whenever you give us the privilege of serving you, as a group or as individuals, during your Annual Meeting or throughout the year, you are always a welcome guest at the KENTUCKY HOTEL.

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.
Contraindications: History of sensitivity to meprobamate.
Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.
Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.
Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.
Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.
Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.
Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 4-67. This 42 year old married white, gravida 5, para 4, was pregnant at term. She had had no prenatal care with this pregnancy. She presented herself at a local hospital and said she was visiting in the state.

The patient stated she felt as if she had been in labor for a week when seen by the nurse at 10 a.m. on May 12, 1967. The nurse contacted the physician on call, who referred her to the chief of the medical staff as this was an out-of-state patient. The patient was advised that she should return to her home and see her family physician for attention. Subsequently, it was learned that she was a resident who had actually delivered several children at the hospital in the past, but because of an unpaid bill stated that she was from elsewhere.

On May 13, 1967, at 6:30 a.m. an ambulance was called to the patient's home. She had delivered; the attendant did not see any bloody clothing or towels. However, he noticed blood dripping to the floor when the patient was transferred from her bed to the ambulance cot. She appeared weak, but had no complaints. The ambulance stopped at a local restaurant and called three physicians, two of whom were aware that the patient was at the hospital the previous day. The patient requested a glass of water at the restaurant.

Enroute to the hospital the patient began screaming and appeared in considerable pain, then ceased all sounds and movement according to the driver and her son who was with them. She was dead on arrival at the hospital.

An autopsy limited to the trunk and head was performed. The positive findings were: 1) right lower lobe of lung contained three infarcts and the left lower lung one infarct. These were secondary to pulmonary embolization, 2) fatty infiltration of the liver, 3) chronic thyroiditis, 4) uterus with a retained placenta. The comments of the summary are quoted because of their interest.

> This is the case of a post partum death complicated by liver and thyroid disease with the terminal episode coming acutely by pulmonary embolization. The mechanisms of death are very complicated, and should be classified under eclampsia and its complications. The fatty infiltration of the liver, which had been present for months, indicated the patient did not receive adequate nutritional elements during her pregnancy. The pulmonary embolism was the cause of death.

Comments

The Committee classified this case as a direct obstetrical death with preventable factors on the part of the patient and the local medical community for not admitting her. The Committee considered the cause of death most likely hemorrhage due to the retained placenta in spite of the autopsy findings in this patient. A retained placenta could well account for excessive blood loss resulting in shock and death.

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8


SPAIN
ARIZONA
FLORIDA
ENGLAND

Our travel-pak for summer cold and allergy sufferers.

istine LP can speed your
ts on their way, by providing
t and continuous relief from the
oms of summer colds and
es. These continuous-release
s contain a vasoconstrictor-
stamine formulation that goes to
apidly and lasts for hours.
when nasal congestion is caused
eated allergic episodes, the
nient twice-a-day dosage of
istine LP makes it easy for most patients to enjoy relief all day and all night. When symptoms are severe, a third dose of one or two tablets may be safely given. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

WHAT'S NEW

in

Medical Progress

Surgical Transplantation

Allan M. Lansing, M.D., Ph.D., F.R.C.S. (C)*

Transplantation of vital organs has become a common procedure in centers where skilled personnel are available in the fields of medicine, surgery and immunology. The state of the art has reached a high level in the case of kidney transplants, so that this is now an established form of treatment for end-stage renal failure. In the case of other organs that require a blood supply for survival and function, however, transplantation continues to be an experimental procedure. The enormous advances in the field of immunology that have been stimulated by the experience in clinical transplantation would in themselves form the basis for a complete review, so our attention will have to be concentrated primarily on the surgical problems. These include the selection of recipients and donors, preservation of organ viability during the transplant, the available methods of preventing and treating the rejection process, and an overall view of the results that have been achieved.

Since organ transplantation is a palliative rather than a curative procedure, certain factors must be considered in selecting the recipient. First, he must have end-stage irreversible disease involving one vital organ system and he must have a short life expectancy. Next, there must be no other form of medical treatment available or suitable for the individual. Thirdly, the patient should have no other serious contraindication such as infection, carcinoma, or even moderately severe diabetes, each of which would be made worse by the drugs employed to suppress rejection. Finally, the patient should have a strong personality with great determination to live and complete faith in his physicians so that he will be entirely cooperative in the strict regimen required in the post-transplant period. Ideally, the patient should also be in the younger age group although successful transplants have been performed in patients over 50. In the case of kidney transplants, an alternative treatment is chronic dialysis, but the patient may be unsuited for this because of geographical, financial, psychological or physical reasons. Selection of a patient for transplant of any other organ is only acceptable if all other forms of medical and surgical treatment have been exhausted and the prognosis without treatment is quite evident to the patient and all the physicians involved. Needless to say, this is a very difficult decision since long-term successes are extremely rare with transplants of heart, liver, lung or pancreas.

Despite these facts, the major problem today is not the selection of recipients but rather the unavailability of donors. The donor must be an individual in the younger age group who is free of infection or carcinoma. Since the organ to be transplanted rapidly deteriorates after the donor's death, transplantation is greatly facilitated if death occurs in the institution in which the operation is to be performed. If the organ is one whose function cannot be taken over by mechanical means in the postoperative period, such as the heart or liver, it is even more essential that a well-functioning organ be transplanted, or death of the recipient will occur shortly after operation. The moral, ethical and legal problems generated by this conflict have put great strains on the teams undertaking transplantation. They can only be resolved by the continued support of physicians practicing in the area and by the education of the public, so that relatives of an individual dying of irreversible brain damage will request that a transplant be considered. As a result of the publicity resulting from transplantation of donors over long distances and the circus-like atmosphere associated with multiple organ transplants, we may be threatened by a psychological "rejection" of the procedure by the public that could be as serious as the ever-present biological rejection of the transplant.

The problems involved in carrying out cadaver organ transplants on an unscheduled emergency basis have led to a search for methods of preserving organ function after removal from the cadaver. Thus, if the transplant can only be done on an emergency basis, the surgical team may not only be tired from a heavy elective schedule, but there will be little opportunity to match the donor and recipient tissues. At present, the usual method employed to preserve an organ is to cool it so that further deterioration of cellular function is delayed for five to six hours, but even this period is far from ideal. The addition

*Professor of surgery and chief of cardiovascular surgery, University of Louisville School of Medicine, Louisville

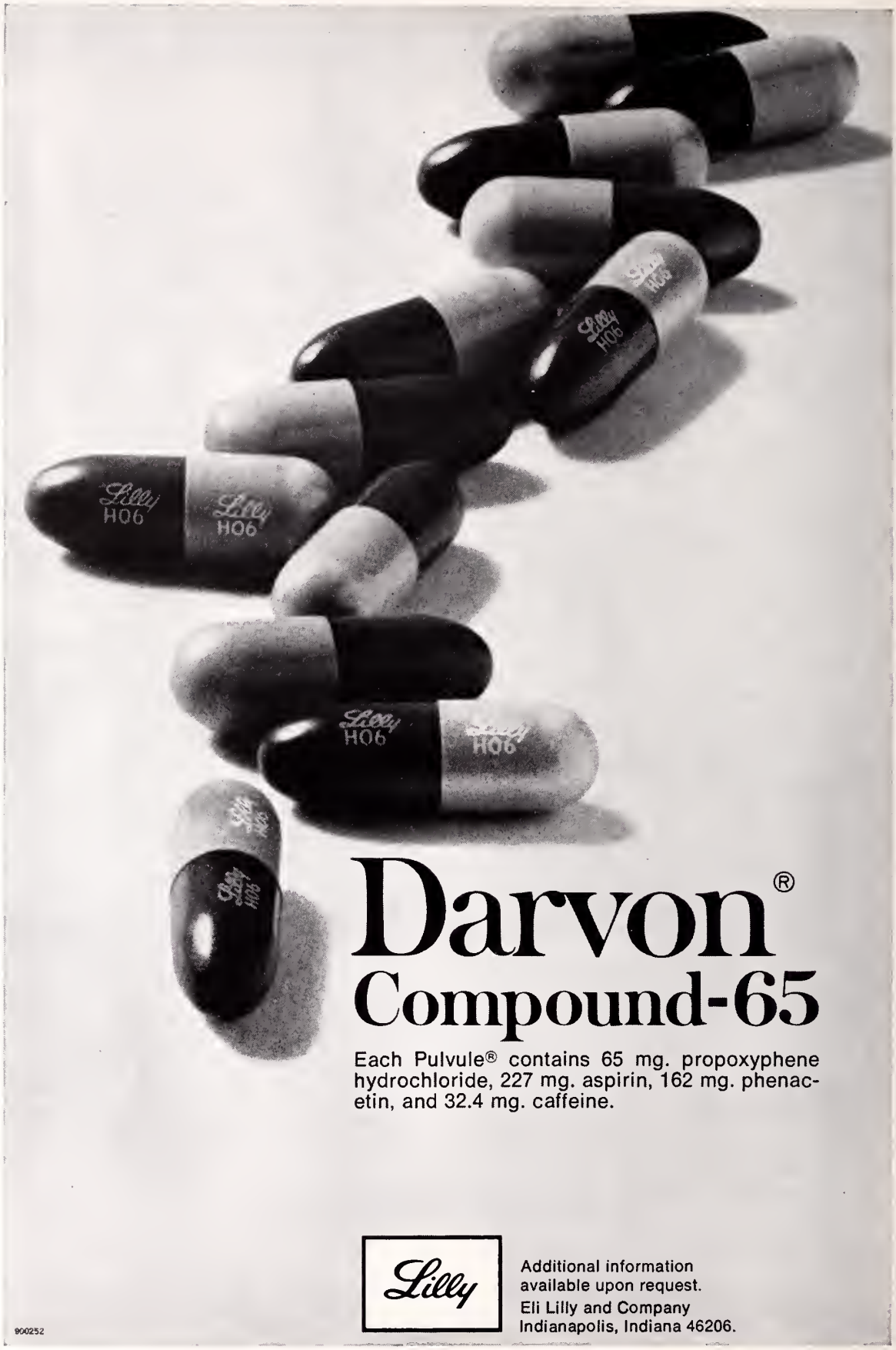
of hyperbaric oxygenation may add a few hours more, particularly in the case of kidney transplants, but after 24 hours there is marked loss of function that makes this technique unsuitable for heart transplants. Perfusion systems to maintain the nutrition and viability of the organ are being developed. At present, the best types include pulsatile flow of a solution that does not contain blood since the platelets, cellular elements, and denatured proteins gradually occlude the small vessels of the graft and lead to increasing edema and loss of organ function within a few hours. Metabolic inhibitors have also been employed in the perfusate to inactivate the enzymes that cause destruction of cell membranes and intracellular structures, but this too is still in a very early stage of development. Despite the success that has been achieved by our present inadequate methods, the future widespread application of organ transplantation will depend to a great extent upon the development of satisfactory methods for organ preservation that will permit a less hectic approach to the operation.

Since rejection of the transplanted organ always occurs except in the case of identical twins, one method to lessen the severity of the rejection is to match the tissues of the donor and recipient as closely as possible. The best choice is usually a close relative of the same blood type, since if one crosses major blood group barriers in organ transplantation the rejection process is more severe. Another approach is to type the leucocytes of the donor and the recipient by comparing their reactions to a panel of antisera obtained from other individuals. Presumably, the more similar the leucocytes of the two individuals, the less the chance of a severe rejection, although this has not yet been definitely established. Mixed lymphocyte culture to determine the severity of the reaction of the donor and recipient lymphocytes to each other has also been employed on the assumption that the reaction will be more violent as the difference between the individuals increases. However, the results of this test are also somewhat variable, and completion of the test requires five to seven days, which prohibits its use in cadaver donors.

Since perfect tissue matching is unlikely to be achieved in the near future, and the ideal method of producing immunological tolerance whereby the body accepts the foreign graft has not yet been accomplished, present methods for support of the graft depend upon immunosuppression. The use of large doses of steroids is one of the basic tools, presumably because of their effect in producing lymphocyte depletion, their anti-inflammatory action that interferes with tissue destruction resulting from antigen-antibody interaction, and perhaps their suppression of antibody formation. Azathioprine is another cornerstone of therapy through interference with nucleic acid synthesis and prevention of mobilization of the lymphoid tissues. Antilymphocytic globulin (ALG) is a biological immunosuppressant derived from horse antiserum prepared by injecting human lymphocytes into the animal. This compound plays a supplementary role by allowing reduction of the dose of steroid and azathioprine, acting perhaps by lymphocyte depletion, by "blindfolding" the antigen detector sites on the lymphocytes, or by sterile activation of the lymphocytes to produce a nonspecific response to ALG that prevents the specific cellular phase of rejection. However, neither steroids, azathioprine, nor ALG has any effect against the hyperacute or the chronic forms of graft rejection that are caused by antibody formation, and each of them has serious side effects: the steroids may produce gastrointestinal ulceration, psychosis, diabetes, and osteoporosis; azathioprine depresses the bone marrow and may cause gastrointestinal ulceration; and ALG can cause serum sickness, nephritis, and hepatotoxicity. Radiation is also used for immunosuppression in the form of local radiation of the graft to destroy the sensitive proliferating lymphocytes that are attacking the transplant and occasionally as extracorporeal radiation of blood as it circulates through an external arteriovenous shunt to produce a generalized depletion of the white blood cells. Lymphocyte depletion can also be produced by creation of a thoracic duct fistula and re-infusion of the fluid after removal of the lymphocytes, but this is a cumbersome method that can be used for a short term only.

Despite all these problems, the results of kidney transplantation are now so satisfactory that it has taken its place as an acceptable and approved method of treatment of irreversible end-stage renal failure. If the graft comes from a related living donor, the success rate may be from 75-90 percent for one year and with a cadaver graft from an unrelated individual, 40-50 percent. This has led to enthusiasm for cadaver transplants of other vital organs, but unfortunately the success rate here is not as great, both because of the shorter period of experience and because of the absence of mechanical support devices to assist the function of the transplanted organ during periods of poor function or rejection. Thus, survival of a heart or liver transplant patient for one year is still rare and lung transplant recipients have not survived even a few months. Endocrine transplants have not been widely tried because of the availability of substitution therapy, and transplantation of the bone marrow is hampered by the fact that the "organ" being transplanted is itself the source of the cells involved in the rejection process and hence a graft versus host rejection takes place.

The future of organ transplantation appears bright despite the present embryonic state of the art, and the enterprise offers great rewards in the knowledge to be gained in the field of immunological disorders including our understanding of the growth and spread of cancer. To achieve widespread success we need methods for storage and preservation of the organs that permit time for adequate tissue typing, computer matching of donor organs and possible recipients, and transfer of the stored organ to the best possible recipient who may live some distance away. These factors combined with more selective immunosuppression or the production of immunological tolerance will make organ transplantation a common practice in the near future.



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 AUGUST, 1969 No. 8

Cancer Chemotherapy
A Practical Approach for the Practicing Physician

J. W. YARBRO, M.D., Ph.D.*
Lexington, Kentucky

Cancer Chemotherapy, when properly used, offers the physician an opportunity to give months and even years of added useful life to the patient with selected advanced neoplastic disease.

IN RECENT years the rapid progress in early diagnosis, surgical excision and radiation therapy of malignant disease have combined to markedly improve the prospects for cure or long-term survival of patients with many types of malignant processes. There remain, however, a large number of malignancies in which attempts at early diagnosis have proved fruitless, radiation therapy ineffectual, and complete surgical excision impossible. It is clear that ultimately the management of advanced neoplastic disease must involve some form of systemic therapy — chemotherapeutic, immunological or both. The recent reports of cure of African lymphoma by cyclophosphamide and of choriocarcinoma in the female by methotrexate have clearly demonstrated that eradication of advanced neoplasia is sometimes possible by the use of drugs alone. The validity of the concept of "total tumor cell kill" by drugs alone has been demonstrated in the experimental animal. Combinations of agents have been shown to produce increased anti-tumor effect without an increase in drug toxicity beyond tolerable levels. The application of these principles to the therapy of acute leukemia in childhood has been rewarded by a dramatic increase in the number of complete remissions and the duration of survival. Continued development of new drugs and new approaches to chemotherapy have encouraged many to expect that an increasing number of malignancies will be treatable by drug therapy in the near future. However, care should be taken not to minimize the toxicity of these drugs, the relatively few types of tumors which *now* respond to chemotherapy, and the relatively low response rates observed. Except for a few well studied drugs and cancers, chemotherapy must be considered an investigative procedure undertaken only after the most careful discussion with each patient of the potential detriment and benefit of therapy.

The essentials of effective cancer chemotherapy may be summarized as follows:

1. Selection of an agent reported to be effective and with which the therapist is familiar.
2. Use of this agent in an adequate dosage regimen with treatment to the point of early toxicity.
3. Careful measurement of the tumor size *before* and after an adequate course of therapy.

*Director of hematology and oncology, University of Kentucky Medical Center, Lexington

4. Continued therapy only if the tumor shows an objective regression.

The two most common errors in cancer chemotherapy are the failure to measure the tumor size before therapy and the failure to give an adequate dose because of a fear of drug toxicity. Both of these errors result in long-term, low-dose, ineffective "palliative chemotherapy" which is neither palliative nor chemotherapeutic. It is clear that the application of the principles stated above will result in a replacement of the commonly used low-dose, long-term chemotherapy with a more intensive chemotherapeutic attack on each patient's neoplasm for a short period of time, and the use of drugs over a prolonged period only when a therapeutic trial had indicated clearly that the patient has benefitted from therapy. The concept that each patient should have an individual therapeutic trial is a logical consequence of the fact that regression rates for most tumors are so low that failure to respond is more common than tumor regression. Therefore, therapy given without some objective criterion of benefit is more likely to be harmful than helpful.

At this point it is necessary to emphasize that most cancer patients who receive chemotherapy under ideal circumstances will note marked subjective improvement. This is less the result of the chemotherapy than of the enthusiasm of the chemotherapist. Unfortunately a deep pessimism with regard to the therapy of advanced cancer pervades the medical profession. This pessimism is invariably conveyed to the patient and often results in a feeling of abandonment and considerable hostility towards physicians. Such hostility is familiar to those experienced in the management of terminal cancer and is often manifested by an inordinate preoccupation with numerous minor manifestations which the patient repeatedly demands that the physician control. The patient directs the physician through an unending sequence of minor symptom management ranging from bowels to bladder to pain to diet to vomiting and back to bowels again in such fashion that the novice physician is often made to feel quite guilty about his inability to control minor symptomatology. It is almost as though the patient, recognizing the injustice of condemning his physician's inability to cure cancer, is nonetheless subconsciously determined to make his physician feel guilty about his management of the case. When a patient with feelings of abandonment and resentment is confronted by a chemotherapist willing to attempt control of his cancer, an unwarranted sense of optimism often results in definite feelings of subjective improvement following chemotherapy. The use of such subjective manifestations of improvement as an indication for continued chemotherapy is to be guarded against. Such therapy may serve only to depress a needed immune mechanism without antitumor effect and may deprive the patient of an effective chemotherapeutic agent which might be discovered if subsequent chemotherapeutic trials with other drugs are used.

The non-investigative drugs presently available and useful in the management of neoplastic disease may be classified as follows:

A. **Hormones**

1. Diethylstilbestrol: 5mg tablets; usual dose 5mg tid; side effects are nausea, vomiting, uterine bleeding, and fluid retention.
2. Testosterone enanthate: (Delatestryl) 200mg/cc for I.M. injection; usual dose 200mg 3 times per week; side effects are masculinization and fluid retention.
3. Hydroxyprogesterone caproate (Delatutin): 250mg/cc for I.M. injection; usual dose 500mg 3 times per week; side effects are minimal.
4. Prednisone: 5mg tablets; usual dose 50-200mg/day; side effects are fluid retention, hypertension, diabetes, peptic ulcer, and psychosis.

B. **Alkylating Agents**

1. Mechlorethamine (Mustargen): 10mg ampules for I.V. use only; usual dose 0.4mg/kg in a single dose repeated as necessary at 4-6 week intervals; side effects are nausea and vomiting (early) and later bone marrow depression.
2. Chlorambucil (Leukeran): 2mg tablets; usual dose 6-12mg/day; the major side effect is bone marrow depression.
3. Melphalan (Alkeran): 2mg tablets; usual dose 4-6mg/day; the major side effect is bone marrow depression.

4. Triethylenethiophosphoramide (Thio-TEPA): 10mg ampules for I.V. or I.M. injection; usual dose 15mg daily x 5 or 3 times per week to toxicity; maintenance dose 5-15mg weekly; the major side effect is bone marrow depression.
5. Busulfan (Myleran): 2mg tablets; usual dose 4-12mg/day; the major side effect is bone marrow depression.
6. Cyclophosphamide (Cytoxan): 500mg ampules for I.V. injection, usual dose 15mg/kg; 50mg tablets, usual dose 100-200mg/day; side effects are bone marrow depression, hemorrhagic cystitis, and alopecia.

C. **Antimetabolites**

1. Methotrexate: 2.5mg tablets, usual dose 2.5-5mg/day; 25mg ampules for I.V. injection, usual dose 25mg every 4-7 days; side effects are oral ulceration and bone marrow depression.
2. 6-Mercaptopurine (Purinethol): 50mg tablets; usual dose 100-200mg/day; side effects are bone marrow depression and jaundice due to bile stasis.
3. 5-Fluorouracil: 500mg ampules for I.V. use; usual dose 12mg/kg/day for 4 or 5 days followed by 6mg/kg/day every other day for 5 to 7 doses or until patient develops burning of lips or diarrhea; maintenance dose 12mg/kg every 1-2 weeks; the major side effect is bone marrow depression.
4. Hydroxyurea (Hydrea): 500mg capsules; usual dose 20-40mg/kg per day; the major side effect is bone marrow depression.

D. **Miscellaneous Agents**

1. Actinomycin D (Dactinomycin): 0.5 mg ampules for I.V. use; usual dose .015mg/kg per day for 5 days; the major side effect is bone marrow depression.
2. Vinblastine (Velban): 10mg ampules for I.V. use; usual dose 0.1-0.2mg/kg every 1-2 weeks; side effects are alopecia, areflexia, and bone marrow depression.
3. Vincristine (Oncovin): 1mg ampules for I.V. use; usual dose .015-.05mg/kg every 1-2 weeks; side effects are peripheral neuropathy and cerebellar dysfunction.

If a therapeutic trial results in an objective regression of the tumor, then continued drug therapy is in order. Maintenance therapy is designed to prevent regrowth of tumor tissue at the least cost to the patient in drug toxicity. For optimal anti-tumor effect the maximum tolerated dose of drug should be used. For those drugs which primarily depress the bone marrow (alkylating agents, antimetabolites, and vinblastine) ordinarily the dose and treatment interval is adjusted to maintain the WBC in the range of 3500 ± 500. This dose is reasonably safe and insures an anti-tumor activity against sensitive tumors. At such time as regrowth of tumor is observed one may immediately shift to therapy with an alternate agent. Unless a maintenance dose adequate to depress the WBC is used, one is often confused at the time of tumor regrowth by the possibility that the maintenance dose has been inadequate and time may be wasted in an effort to control a resistant tumor by raising the dose of drug; failure to make such an effort might result in premature termination of therapy with an effective agent.

Neoplasms responsive to chemotherapy and the agents of choice may be classified as follows:

A. **Neoplasms in which chemotherapy may result in a cure.**

1. Choriocarcinoma in females treated with methotrexate may be cured in up to 80% of the cases. The drug of second choice is actinomycin D.
2. African lymphoma of Burkitt treated with cyclophosphamide may be cured in 20-25% of the cases.
3. Wilm's tumor of childhood treated with actinomycin D in combination with surgery and radiation may be cured in an as yet undetermined percent of cases, possibly as high as 80% in comparison to a lower percent cured by surgery and radiation alone.

B. **Neoplasms in which tumor regression may be expected in over 75 percent of treated cases.**

1. Acute leukemia of childhood: Combination therapy is preferred here, for example with vincristine + 6-mercaptopurine + methotrexate + prednisone.

2. Hodgkins disease: A combination of vincristine + cytoxan + prednisone should produce a remission in over 90% of cases; mechlorethamine, cyclophosphamide, or vinblastine used alone should give about 65% remissions.
3. Lymphosarcoma: Treatment similar to that used for Hodgkins disease.
4. Chronic myelogenous leukemia: Busulfan or hydroxyurea should give good control of most patients until blastic crisis ensues.
5. Chronic lymphatic leukemia: Chlorambucil is the drug of choice.
6. Carcinoma of the prostrate: Stilbestrol is the drug of choice.

C. **Neoplasms in which tumor regression may be expected in 50-75 percent of treated cases.**

1. Reticulum cell sarcoma: Therapy as in Hodgkin's disease or the use of vincristine alone.

D. **Neoplasms in which tumor regression may be expected in 25-50 percent of treated cases.**

1. Carcinoma of the breast: Post-menopausal patients should receive stilbestrol initially. When tumor is no longer hormone responsive the chemotherapeutic agents of choice are 5-fluorouracil or cyclophosphamide.
2. Carcinoma of the colon: 5-fluorouracil is the drug of choice and cyclophosphamide is the drug of second choice.
3. Carcinoma of the ovary: Thio-TEPA is the drug of choice and chlorambucil is the drug of second choice.
4. Carcinoma of the endometrium: Hydroxyprogesterone is the drug of choice.
5. Embryonal cell carcinoma of the testis: The usual therapy is actinomycin D + chlorambucil + methotrexate given in combination. An experimental drug, mithramycin, may be superior.
6. Acute myelogenous leukemia: Combination chemotherapy as for childhood leukemia is usually recommended. An experimental drug, daunomycin, may be superior.

E. **Neoplasms in which tumor regression may be expected in 10-25 percent of treated cases.**

1. Multiple myeloma: Melphalan or cyclophosphamide are the drugs of choice.
2. Carcinoma of the lung (bronchogenic): Cyclophosphamide in very high dosage intravenously followed by methotrexate intravenously after recovery from the toxic effects of cyclophosphamide may produce significant regression of tumor.
3. Neuroblastoma: Cyclophosphamide or vincristine.
4. Renal cell carcinoma: Hydroxyurea.

F. **Neoplasms in which tumor regression occurs in less than 10 percent of treated cases.**

1. Squamous cell carcinoma of the head and neck.
2. Carcinoma of the liver, gall bladder, and bile ducts.
3. Carcinoma of the stomach and esophagus.
4. Carcinoma of the pancreas.
5. Carcinoma of the cervix.
6. Malignant melanoma.
7. Sarcoma of bone and soft tissue.

A common and often troublesome problem is the patient who has recently been operated for malignancy and in whom it has been necessary for the surgeon to incompletely remove the tumor, yet who has no clinically measurable tumor tissue. With the exception of groups A, B, and C listed above one should not undertake chemotherapy in such patients. The probability of response is too low to make such therapy worthwhile. An even more troublesome problem is that of adjuvant chemotherapy post-operatively in patients in whom a cancer operation has apparently removed all of the tumor. Careful studies to date have not demonstrated this approach to be of value. Such therapy should not be thought of as harmless; under certain experimental circumstances in animals, metastatic seeding of circulating tumor cells takes place *only* after injury to the animal by the use of anti-tumor drugs.

(Continued on page 621)

Case Report: A Familial Microepidemic of Histoplasmosis

Kenneth S. Welsh, M.D.* Ibrahim Ildirim, M.D.**
and Michael L. Furcolow, M.D.***

Lexington, Kentucky

Eight cases of histoplasmosis occurred in a family in western Kentucky. The cases came to medical attention two months after the family moved into a rural homestead.

Throughout the past few years a series of epidemics of histaplosmosis among various groups have been reported by such authors as Loosli[1], Grayston and Furcolow[2], and Lehan and Furcolow[3]. In general, the epidemics reported have involved diverse groups such as Boy Scouts, farm workers, occasionally families, and have generally been related to association of the individuals involved with contact with soil mixed with bird excreta. A detailed family study by Bertan et al[4] has shown the need for a closer look at families in cases of suspected or proven histoplasmosis as a means for shedding more light on the epidemiology of histoplasmosis.

In November, 1967, the Department of Community Medicine was notified by the Hazelwood Sanitarium at Louisville, Kentucky of the admission of two children from the same family to the sanitarium with acute pulmonary histoplasmosis and suggested that the family might well warrant further investigation.

The purpose of this paper is to present the results of the investigation of a microepidemic of histoplasmosis occurring in a rural Kentucky family living in the Ohio River Valley.

Family History

The family, consisting of father, mother, and seven siblings, were living in a dilapidated four-room dwelling in a remote location on a bluff overlooking the Ohio River near Mooleyville, Breckinridge County, Kentucky. The family had moved to this dwelling in March, 1967, from another rural tenant farm located in Breckinridge County. Prior to March the dwelling had been used as a farm animal shelter and chicken coop for several months. The H. family cleared out the animal detritus including chicken manure and made the dwelling somewhat more habitable. Water was obtained from a cistern. There were no toilet facilities. The only heat in the house was from a wood and coal burning stove in the living room. The cash income of the family was extremely limited, amounting to somewhat less than $100 during 1966. Much of the food consumed by the family was home grown with supplementation through the commodities distribution program. The three school age children received hot meals at school. Medical care only for emergency situations was available. Dental care was virtually non-existent.

In April, 1967, one month after moving to the new dwelling, the first child, W.E.H., a six-year-old white male, and then the second child, J.R.H., a five-year-old white female, developed fever and malaise and a productive cough with a yellowish sputum. In May, all of

*Chief resident (deceased), department of community medicine, University of Kentucky Medical Center, Lexington
**Fellow, department of community medicine
***Professor and acting chairman, department of community medicine

the other family members developed coughs which have continued to the present time.

On May 19, 1967, W.E.H., and on May 21, 1967, J.R.H. were hospitalized at Children's Hospital, Louisville, for acute histoplasmosis. The hospital findings of W.E.H. were as follows: the liver was 5 cms. below costal margin and the spleen tip was palpable at the left costal margin. Histo skin test was 7 mms induration and PPD was negative. Complement fixation for histoplasmosis yeast was 1/256. The chest x-ray showed bilateral pulmonary diseases compatible with histoplasmosis. He entered another hospital in October, 1967, with a pulmonic infiltrate, cough, and fever. Only symptomatic therapy was given during both hospitalizations.

The hospital findings of J.R.H. were as follows: the liver was 6 cms. below right costal margin and the spleen was not palpable. Cervical lymph nodes were shotty and palpable, and nodes were also palpable in left axilla and both inguinal regions. Complement fixation for histoplasmosis yeast was 1/256. Pulmonary infiltrates were seen on x-ray. She entered another hospital in October, 1967, with a finding of chronic cough, fever and continued infiltrates on chest x-ray. Her condition remained relatively stable during a two-week hospitalization and she was subsequently discharged without specific therapy to be followed in the outpatient clinic.

Family Study

Visits were made to the family by the authors during November and December, 1967, to collect more data and to undertake epidemiologic investigation of the family. All nine family members were given physical examinations, skin tests PPD-S for tuberculosis, PPD-B for atypical tuberculosis of Battey strain and histoplasmin tine test, and had blood drawn for serology and hematocrit. Chest x-rays were taken of the entire family. Blood was also drawn from their two dogs for serology. Cultures were taken from various locations in and around the house and from a chicken house near the home in an attempt to find *Histoplasma capsulatum*. Medical and social histories were taken.

History and physical examination findings and x-ray and laboratory results for the family members are summarized in Table I. Consideration of all data available on the nine members of the family leads to the belief that all of the children except possibly J.A.H. had suffered from acute histoplasmosis. J.A.H. may have had a coincidental pneumonia (non-histo) which responded rapidly to penicillin therapy.

The positive finding on physical examinations, skin tests and laboratory and x-rays on the H. family are presented below:

J.H. 41-year-old male (Father). He has moderate (++) dry cough; histo-tine: 12 mm; complement fixation: Histo yeast: 1/8, chest x-ray: An area of infiltration extends downward and laterally from the hilar areas. This has the appearance of inflammatory disease.

M.H. 28-year-old female (Mother). She has severe (+++) dry cough. Auscultation of chest: scattered fine and course rales over both lower lung field posteriorly, course rales in right apical area. Scattered fine and course rales right anterior lung field. No clearing with cough. Histo-tine: 11 mm, complement fixation: histo-yeast: 1/8, PPD-B: 10 mm. Chest x-ray bilateral infiltration.

E.J.H.: 9-year-old Male. Cough ++, lxl cm anterior cervical and 6x6 mm axillary and inguinal adenopathy, firm, rubbery, not painful. Auscultation of chest: increased bronchial breathing (harsh, rough). Ring worm of scalp and abdomen. Histo-tine: 2-1-0-1 mm. Chest x-ray: the left hilar shadow is slightly accentuated.

B.J.H.: 8-year-old Female. Cough +++, lxl cm anterior cervical, and 6x6 mm inguinal lymphadenopathy, firm, rubbery, non-tender. Hyperemia of right ear drum. Auscultation of chest: sibilant and course rales throughout all lung fields but particularly pronounced over both middle and lower posterior lung fields. Histo-tine: 2-1-2-0 mm. Complement fixation, histo yeast: 1/64. Chest x-ray: there is considerable bronchiovascular thickening in the right cardiophrenic sulcus which has the appearance of residuals of previous inflammatory disease.

W.E.H. 6-year-old Male. Cough ++, 6x6 mm anterior cervical, axillary and inguinal lymphadenopathy. Ring worm of scalp. Histo-tine: negative, complement fixation, histo

yeast: 1/512, histo mycelial: 1/8; Histo precipitin +, complement fixation blasto: 1/16. Chest x-ray; bilateral pulmonary infiltration.

J.R.H.: 5-year-old Female. Cough +++, 7x7 mm anterior cervical, axillary and inguinal nodes. Auscultration of chest; right posterior middle and lower lung fields have crepitant, sibilant and post-tussive rales, Histo-tine: 2 1/2-2 1/2-2 1/2-2 mm. Complement fixation Histo yeast: 1/1024, Histo Mycelial; 1/16, histo precipitin: +++, complement fixation, blasto: 1/8. Chest x-ray: considerable mottled density almost the entire area of both lungs excepting the supraclavicular area. The shadows appear rounded and lie rather close together.

B.S.H.: 4-year-old Female. Cough ++, 5x5 mm anterior cervical nodes, auscultation of chest: increase in bronchial breath sounds. Histo-tine: 13 mm. Complement fixation, histo yeast: 1/256, chest x-ray: bilateral infiltration.

B.K.H.: 2-year-old Female. Cough ++, 5x5 mm anterior cervical nodes. Auscultation of Chest: wheezing and sibilant rales over all lung fields with prolonged expiratory phase. Liver palpable, soft, non-tender, 2 cm below R. costal margin at MCL. Histo-tine: 16 mm, complement fixation histo yeast: 1/128, Histo Mycelial: 1/16, histoprecipitin: ++++, chest x-ray, shows infiltration in right lower lobe.

J.A.H.: 9/12-year-old Female. Cough +++, 4x4 mm anterior cervical nodes. Auscultation of chest: sibilant and course rales scattered over all lung fields. Liver palpable 3 cm below right costal margin at MCL. Histo-tine: negative. Complement Fixation and precipitin tests were negative for Histo. Chest x-ray: there is minimal infiltration involving the right lung field.

The family has two dogs. They were bled for laboratory study. Their precipitation and complement fixation test for histo was negative. Collection of dust from the wooden floors did not yield positive culture for *Histoplasma capsulatum*. Four soil samples from the chicken house yielded positive cultures for *Histoplasma capsulatum*.

TABLE 1

SUMMARY OF PHYSICAL EXAMINATION, SKIN TESTING, LABORATORY AND X-RAY WORK AT THE TIME OF INVESTIGATION ON H. FAMILY

						Serology						
			Skin Test Results			Precipitin		Complement Fixation			Chest	
Name	Sex	Age	Histo Tine	PPD-S	PPD-B	Histo	Histo Y	Histo M	Blasto	Cocci	X-Ray	Physical (Chest)
JH	M	41	12mm	0	0	Neg	1:8	Neg	Neg	Neg	Bilat Inf.	Normal
MH	F	28	11mm	0	10mm	Neg	1:8	Neg	Neg	Neg	Bilat Inf.	Abnormal
EJH	M	9	2-1-0-1mm	0	0	Neg	Neg	Neg	Neg	Neg	L Hilar Inf.	Abnormal
BJH	F	8	2-1-2-0mm	0	0	Neg	1:64	Neg	Neg	Neg	Brocho Vascular Thick-ening	Abnormal
WEH	M	6	0	0	0	+	1:512	1:8	1:16	Neg	Bilat Inf.	Abnormal
JRH	F	5	2½2½2½2mm	0	0	+++	1:1024	1:16	1:8	Neg	Bilat Inf.	Abnormal
BSH	F	4	13mm	0	0	Neg	1:256	Neg	Neg	Neg	Bilat Inf.	Abnormal
BKH	F	2	16mm	0	0	++++	1:128	1:16	Neg	Neg	RLL Inf	Abnormal
JAH	F	9 mo	0	0	0	Neg	Neg	Neg	Neg	Neg	R Lung Inf.	Abnormal

Histo Y=Yeast Phase Antigen

Histo M=Mycelial Phase Antigen

Discussion

Perhaps the most important question in the spread of histoplasmosis in the highly endemic area is whether the disease is contracted in general by more or less dissemination of the spores or whether it is contracted at local sites by stirring up the spore bearing dust. From the preceeding epidemic investigation, it is clear that at least in this family the cause of the epidemic was the moving of the family into an abandoned chicken house and the stirring up of dust associated with its clearing. Although the fungus was never isolated from the dust inside the house, it was isolated from the chicken coop and there is no question that most if not all the family members had an acute attack of histoplasmosis shortly after moving into this house.

The evidence presented in this paper supports the concept that the acquisition of histoplasmosis even in areas where it is very prevalent is probably associated with a series of small epidemics associated with visits by persons or families or groups to areas in which the organism is growing in the soil and the stirring up of these soil sites. It is also apparent as has been stressed before by Loosli and others, that these sites are most often associated with the mixture of bird manure with the soil in order to furnish a favorite climate for the growth of the organism.

Summary

A family microepidemic of histoplasmosis is reported from western Kentucky involving eight persons, both adults and children. The occurrence of the epidemic was associated with the family moving into an old abandoned chicken house and stirring up the dust presumably laden with *Histoplasma capsulatum* since all family members were infected. Although the organism was not recovered from this site, the simultaneous infection of most of the family members suggests that it certainly was the cause of their infection.

Bibliography

1. Loosli, C. G.: Histoplasmosis—Some Clinical, epidemiological and laboratory aspects. *Med Clin. North America, 39:* 171-199, 1955.

2. Grayston, J. T., and Furcolow, M. L.: The occurrence of histoplasmosis in epidemics—epidemiological studies. *Am. J. Pub. Hlth, Part I, 43*:665-676, 1953.

3. Lehan, P. H. and Furcolow, M. L.: Epidemic histoplasmosis. *J. Chron. Dis., 5*:489-503, 1957.

4. Bertan, M., Smith, C., and Furcolow, M. L.: Histoplasmosis in Infancy: A family study. *Dis. Chest. Am. Col. Chest Phys., 50*:323-324, No. 3, September, 1966.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Tracheobronchial and Esophageal Foreign Body Extraction in Infants and Children†

Edwin Nighbert, M.D.,* Robert Combs, M.D.**
and J. Kent Trinkle, M.D., F.A.C.S.***

Lexington, Kentucky

Aspiration of a foreign body into the esophagus or trachea is a medical emergency. Rapid recognition and treatment are essential to avoid a patient referral to the coroner.

ASPIRATION of foreign objects into the esophagus or the tracheobronchial tree is common in infants and children. When an infant can maneuver a hand to its mouth, it is prone to ingest all types of foreign matter from blanket fuzz to safety pins. Even inadequately chewed food particles may be aspirated. This article is a review of the experience gained during the past seven years while treating 26 infants and children with foreign body aspiration. Endoscopic extraction of the object was required in each case. Table 1 summarizes the data obtained from these 26 patients.

Tracheobronchial

There were 15 patients with tracheobronchial foreign bodies. The average age was 3.8 years with a range of 14 months to 10 years. Both sexes were equally represented. Hospitalization averaged 4.9 days. In 13 patients there was a definite history of foreign body ingestion or of choking while eating. Dyspnea was present in 14 patients, coughing in 11, cyanosis in nine, and wheezing in seven. Abnormal physical findings were present in 14 of the 15 patients.

Chest x-rays, including films in inspiration and expiration, were diagnostic in eight patients, helpful in five and normal in two. Hyper-expansion of the involved side with mediastinal shift is diagnostic if it is present; however atelectasis, pneumonia, or lung abscess may be noted instead. Figure 1 shows a typical radiograph of a child taken four hours after foreign body aspiration. Ten of 15 patients had a white blood cell count 10,000/mm^3; but only six had a temperature elevation of 101° or greater.

Eleven foreign bodies were organic — including seven nuts and two beans. The four inorganic particles were toy bullets, a bullet casing and a ball point pen cap. Six objects were in the right mainstem bronchus, six in the left mainstem bronchus, and two in the trachea.

Removing a foreign body from the tracheobronchial tree is difficult and hazardous.[1] Organic lesions cause an intense inflammatory reaction with a progressive increase in mucosal edema. Most patients require general anesthesia. Dexamethasone, 2-4 mg. intravenous, and topical ¼% Neo-Synephrine reduce the edema and facilitate extraction. A 3, 5 or 7 mm. bronchoscope is inserted and the foreign body removed intact if possible - organic objects usually are fragmented during removal. If the lesion is not easily dislodged or if respiratory distress is severe, tracheostomy should be performed to improve ventilation and allow a larger bronchoscope to be inserted. Saline

†*From the division of pediatric and cardiothoracic surgery, department of surgery, University of Kentucky Medical Center, Lexington. Presented at a meeting of the Kentucky Chapter, American College of Surgeons, May, 1969.*

**Assistant resident, department of surgery*
***Intern, department of surgery*
****Assistant professor, department of surgery*

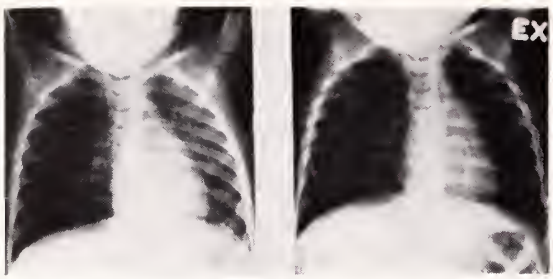


FIGURE 1 illustrates a hyperinflated right lung due to the "ball-valve" action of a peanut in the right main bronchus. The x-ray on the left is taken during inspiration and on the right in expiration. Note that the heart and mediastinum are shifted toward the left by the overinflated right lung.

lavage is helpful in removing fragments. If symptoms persist, bronchoscopy should be repeated to eliminate the possibility of a retained fragment.

Large tracheobronchial foreign bodies may cause complete respiratory obstruction and death. Smaller organic objects evoke such intense inflammation that mucosal edema may cause airway obstruction after a few hours. There were two cardiac arrests secondary to hypoxia—both patients survived but required tracheostomy for ventilation and extraction. Postoperative 12 patients were placed in a croup tent and 10 were given antibiotics.

Esophageal

Eleven patients had esophageal foreign bodies. The average age was 3.3 years with a range of 11 months to 12 years. There were six boys and five girls. The hospital stay averaged 2.3 days with a range of one to 14 days. In 10 patients there was a history of ingestion of a foreign object, and six of 11 complained of dysphagia. The only abnormal physical findings were due to aspiration pneumonia in two patients.

All the esophageal foreign bodies were radiopaque and were apparent on the x-ray. Figure 2 shows an x-ray of a coin lodged at the cricopharyngeus muscle near the junction of the pharynx and esophagus. Seven objects were located at the cricopharyngeus, three at the level of the aortic arch, and only one lodged in the distal esophagus. Foreign bodies may be extracted with the laryngoscope if located at the pharyngoesphageal junction. Distal lesions require the use of the esophagoscope. If the position or the shape of the object indicates that it might be hazardous to attempt extraction, it frequently can be manipulated into the stomach. Foreign bodies in the stomach usually pass through the remainder of the gastrointestinal tract; however, the physical and chemical characteristics of the object should be noted. Long or pointed foreign bodies may perforate the mucosa and have difficulty negotiating turns[2]. Lead objects in the gastrointestinal tract more than two weeks can cause lead poisoning[3]. Yellow and orange wax crayons contain paranitraniline and can cause methemoglobinemia.[4] Nine of the 11 esophageal foreign bodies were easily extracted and two were pushed into the stomach and passed without incident. There were no esophageal perforations and no deaths.

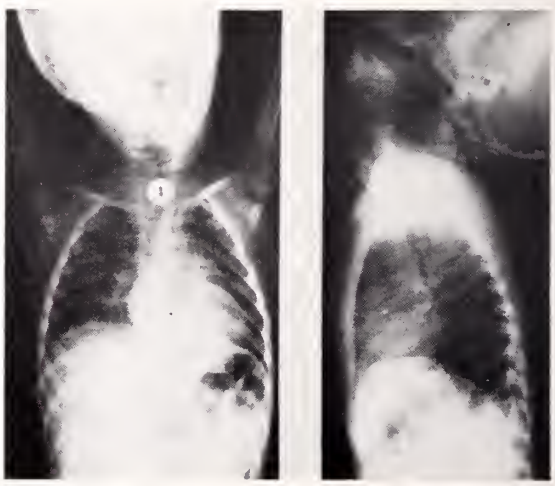


FIGURE 2 illustrates an x-ray with a radio-opaque foreign body lodged at the level of the cricopharyngeus muscle. Objects in the esophagus lodge horizontal to the frontal plane, but foreign bodies in the larynx or trachea are usually vertical to this plane.

Summary

The experience gained in treating 26 patients with tracheobronchial or esophageal foreign bodies is presented. There were no deaths, but two patients with tracheobronchial lesions had cardiac arrest. Abnormal physical findings

TABLE 1

INFANTS AND CHILDREN WITH FOREIGN BODY ASPIRATION

	Tracheobronchial (15)	Esophageal (11)
Mean Age in Years	3.8	3.3
Age Range	14 mo. — 10 yr.	11 mo. - 12 yr.
Sex	8 Male 7 Female	6 Male 5 Female
Hospital days-Average & Range	4.9 (1-13)	2.3 (1-14)
Foreign Body: Organic	6 Peanuts 1 Piece apple 1 Hazelnut 1 Popcorn 2 Beans	0
Inorganic	2 Bullet hulls 1 Plastic bullet 1 Ball pen cap	6 Coins 1 Metal Washer 1 Bobjack 1 Pear 1 Link chain saw
Duration	3 hr. — 2 mo.	4-24 hr. (3 unknown)
History and Symptoms	Coughing - 11 Wheezing - 7 Cyanosis - 9 Dyspnea - 14 Aspiration by hx - 13	Difficulty swallowing - 6 Vomiting - 1 Choking - 1 Anorexia - 1 Aspiration by hx. - 10
Physical	Wheezing - 9 Fever - 6 Retraction - 11 Dyspnea - 12 No findings	Dyspnea - 2 Cough - 1 Chills & Fever - 1 Retraction - 1 Wheezing - 1 No findings - 9
X-ray: Opaque	0	11 (100%)
Non-Opaque	15 (100%)	0
Diagnostic	8 (53%)	11 (100%)
Consistent with Diagnosis	5 (33%)	0
Not Diagnostic	2 (22%)	0
WBC — over 10,000/mm^3	10 (66%)	5 (45%)
Temperature—over 101°	6 (40%)	1 (9%)
Location	Right Bronchus - 6 Left Bronchus - 6 Trachea - 2 Not recovered - 1	Cricopharyngeus - 7 Aortic Arch - 3 Distal Esophagus - 1

Table 1 summarizes the significant data obtained from 26 infants and children with tracheobronchial or esophageal foreign bodies.

were present in 14 of 15 patients with tracheobronchial foreign bodies and in only two of 11 with esophageal lesions. Roentgenographs were diagnostic in all esophageal foreign bodies and in 53 percent of tracheobronchial lesions.

References

1. Holinger, P.H. and Johnston, K.C.: Foreign Bodies in the Air and Food Passages. *Pediat. Clin. North America*, 1:No. 4, 1954.
2. Erbes and Bobbitt: Foreign Bodies in the Alimentary Tract of Infants and Children. *J. Lancet*, 185:247, 1965.
3. Biehusen, F.C. and Pulaski, E.J.: Lead Poisoning After Ingestion of a Foreign Body Contained in the Stomach. *New England J. Med.*, 254:1179, 1959.
4. Clark, Esther B.: Poisoning Due to Ingestion of Wax Crayons. *J. Amer. Med. Assoc.*, 135:917, 1947.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201

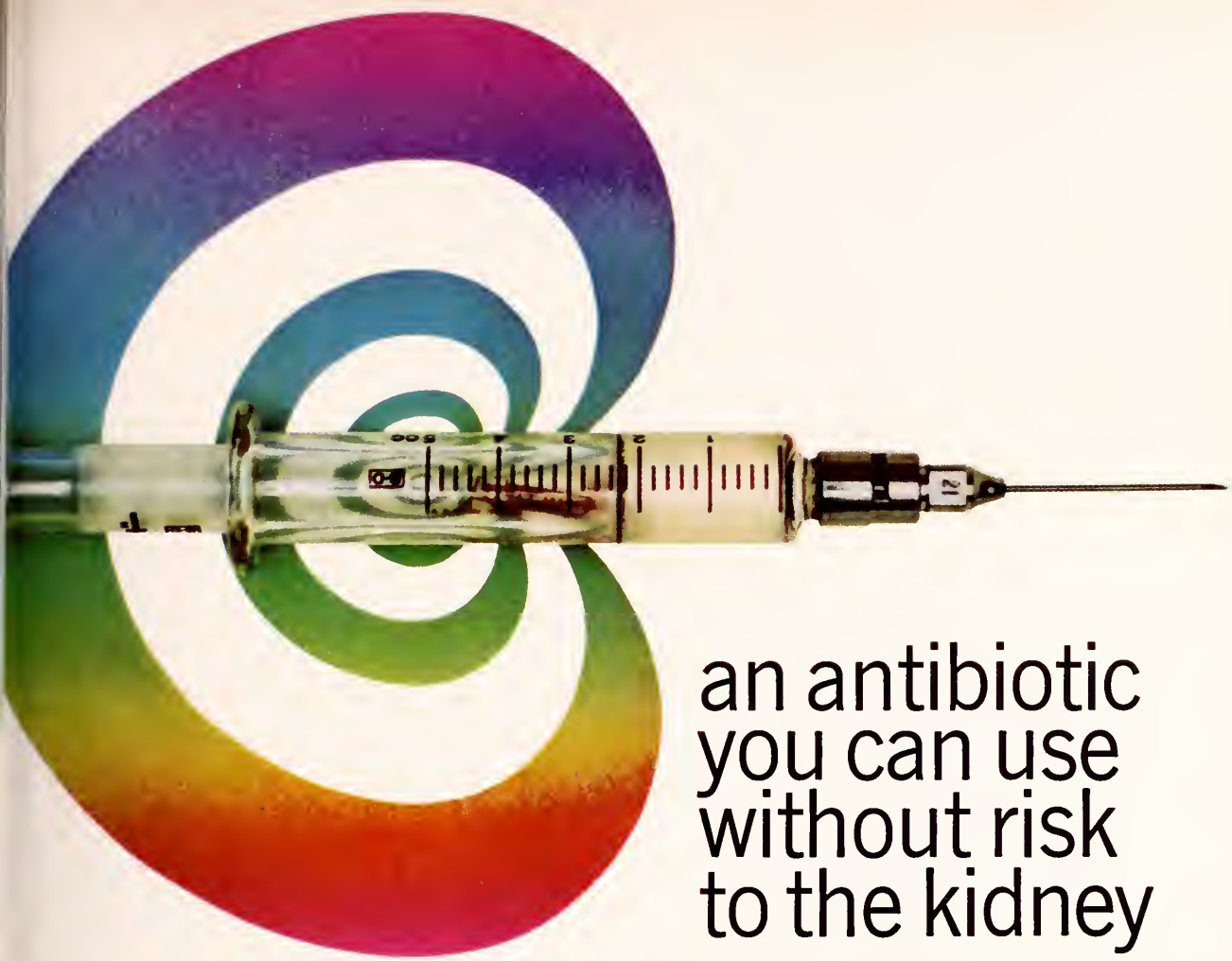
50%

WHY PAY IT???

You don't have to with our new BUSINESS & PROFESSIONAL PRE-COLLECTION PLAN. All monies come direct to you.

GUARANTEED TO WORK

Write for full details, P.O. Box 172, Harlan, Kentucky 40831



an antibiotic you can use without risk to the kidney

Polycillin-N®

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

PRESCRIBING INFORMATION. 11—1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles. **A.H.F.S. Category 8:12.16**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, 'weak

Flagyl®
brand of
metronidazole

simplifies vaginitis therapy

The effectiveness of Flagyl in *Trichomonas vaginalis* vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. ▪ The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

simple Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.

complete Flagyl is the only medication available that is able to reach all the crypts, glands and cavities of the female urogenital system as well as reservoirs of reinfection in male trichomonas carriers.

lasting Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

nausea," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: In the Female. One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases, in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the *oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the *sole* form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets 250 mg.
Vaginal inserts . . . 500 mg.

G. D. SEARLE & CO.
Research In the Service of Medicine

941

Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
56568

–The lowest priced tetracycline–nystatin combination available–



★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

SPECIAL ARTICLES

More On Medicare And Medicaid†

WASHINGTON, D.C.—The Internal Revenue Service plans to audit the federal income tax returns of physicians and other health practitioners who have received more than $25,000 a year in medicare and medicaid payments.

Plans for the special audit were disclosed by IRS Commissioner Randolph W. Thrower at the first of a series of public hearings the Senate Finance Committee is holding in its investigation of the rising costs of the two government health care programs. He said the Department of Health, Education and Welfare had agreed to require intermediary insurance carriers to use physicians' social security numbers on reports of payments under the program in the future.

Finance Committee Chairman Russell B. Long (D., La.) estimated "possibly as many as 10,000" had been getting upwards of $25,000 a year under the programs. Thrower said the initial audits would be for 1967 and would be limited to those receiving more than $50,000.

Long said that the investigation of the committee's staff so far showed "widespread abuse, and fraud, as well as lax administration."

Robert M. Ball, social security administrator, reported his investigators had looked into more than 700 possible fraud cases under medicare. He said more than 300 of these cases were still in some stage of inquiry, and that 14 had been turned over to the Justice Department for prosecution.

"But these should not be taken as a reflection on the 200,000 doctors participating in medicare," Ball said. He added a bigger problem than outright fraud were "cases that don't quite become fraud."

HEW Undersecretary John G. Veneman told the committee that the Nixon Administration wants congressional authority to stop medicare payments to doctors who overcharge, use inferior supplies or engage in fraud.

"Under present medicare law, there is no authority for the program to deny reimbursement to a licensed practioner, who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful," Veneman said.

"We are recommending authority . . to discontinue future reimbursement and to put all parties on notice to this effect where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses."

Commenting on the hearings, Dwight L. Wilbur, M.D., president of the American Medical Association, said that the vast majority of physicians serving medicaid patients are not overcharging for their services.

"Most physicians," Doctor Wilbur said, "are acting honorably and with utmost restraint. Fortunately, very few M.D.'s participating in medicaid are guilty of overcharging and otherwise exploiting the program. Such exploitation by a minuscule minority was unavoidable . . .

". . . The medical profession is making a great effort to identify and weed out dishonest doctors who betray their oath as professional men serving the public. We have been successful in this search, but a few physicians remain who still are not identified. We shall search them out and expose them, for the good of the entire profession."

Meantime, HEW issued a regulation limiting the fees paid by states to physicians, dentists and other health practitioners under medicaid.

†*This material appeared in the regular monthly summary of Washington news prepared by the Washington office of the American Medical Association, July 7, 1969.*

Under the regulation, a state's medicaid payment to a physician for a service will be limited, with one exception, to the 75th percentile of the customary charge—the maximum customary fee of 75 per cent of the physicians in the area.

If a state has been paying more than the 75th percentile of the customary charge, it must not exceed the medicare level, about the 83rd percentile. A medicaid official said that only two states may have to roll back their fees, but declined to name them.

After July 1, 1970, states may request permission to increase physicians' fees above the 75th percentile if two conditions are met:

1. The average percentage increase requested above the 75th percentile on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education and Welfare.

2. Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

The new fee regulation also requires states to revise their medicaid plans to include descriptions and details of their payment structures. A state that wishes to revise its payment structure for practitioners' services or change the payments authorized under it may not do so until the proposed changes have been approved by the Secretary of Health, Education and Welfare or his representative.

States that begin their medicaid programs after July 1, 1969, must arrange their payment structures so that fees do not exceed the 75th percentile of customary charges.

HEW estimated the regulation would result in a saving of $65 million in the first year.

Despite a strong protest by the American Hospital Association, HEW discontinued the overhead medicare-medicaid percentage allowance paid to hospitals, extended care facilities and other institutional providers. It was two per cent for non-profit and one-and-one-half per cent for proprietary institutions. The action was effective July 1, 1969.

Another new medicaid regulation requires states to provide periodic health screening, diagnosis, and treatment for all eligible youths under 21 years of age, effective July 1, 1969.

HEW also established a new classification of institution—called intermediate care facility—eligible to receive federal contributions for the care of aged, blind or disabled recipients or public assistance is covered in another regulation. This should reduce costs of medicaid by allowing states to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower cost institutions, HEW said.

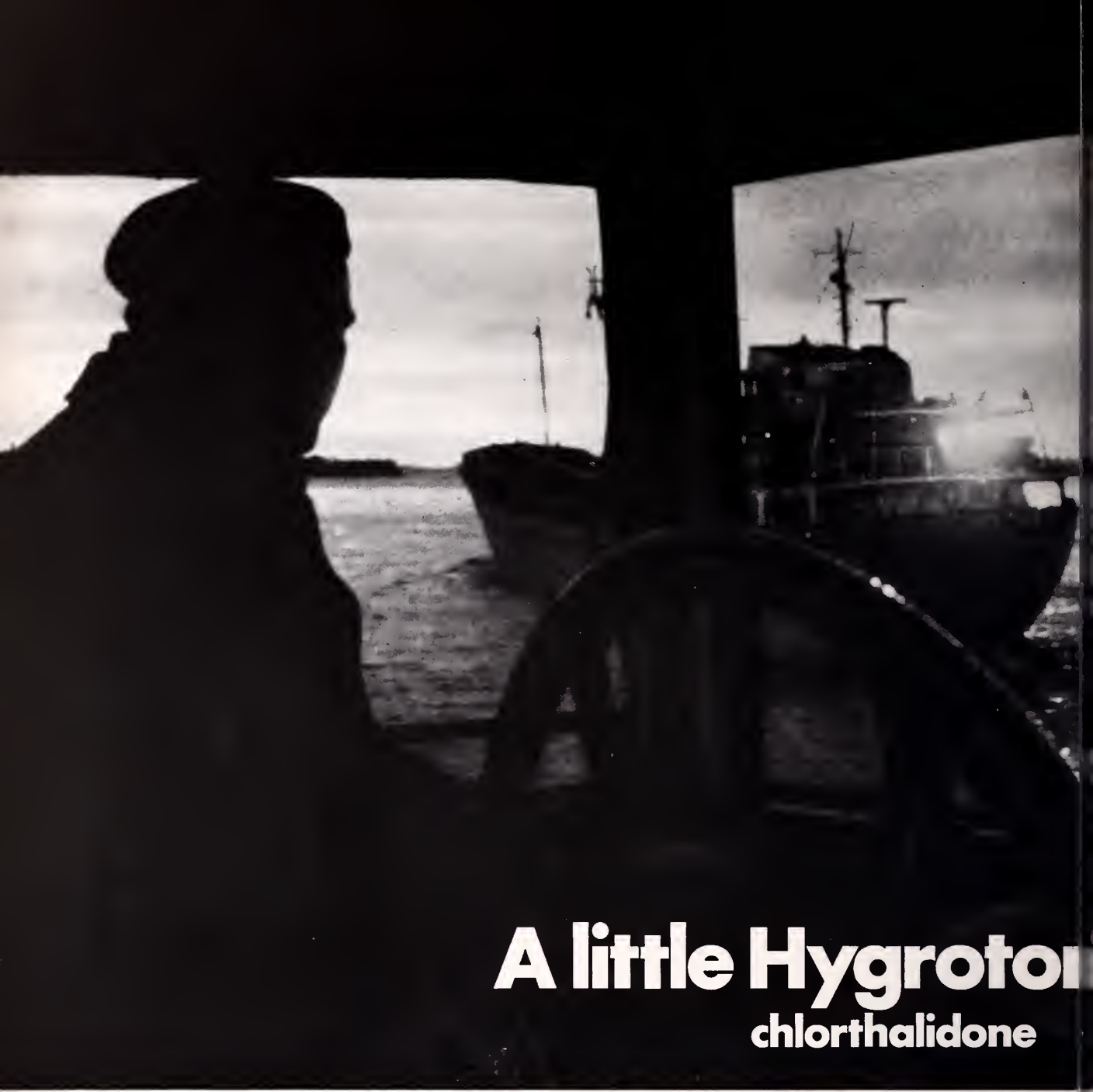
1969 KMA Annual Meeting

September 23-25

Convention Center

Louisville

(See pages 593-616 for details)


A little Hygroton
chlorthalidone



can work a long diuretic day

all the way from one daily tablet to the next to help control edema and hypertension

Its prolonged action usually provides smooth, sustained diuretic effectiveness; real one-a-day dosage, right from the start; convenience and economy.

Hygroton, chlorthalidone, can cause side effects. And it's contra-indicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6674

EDITORIALS

1969 KMA Annual Meeting

THE 1969 KMA Annual Meeting will be be held in the Louisville Convention Center from September 23 through September 25. An excellent attendance may be expected by Kentucky physicians. Attendance figures of the recent annual meetings indicate that approximately 50 percent of the Kentucky physicians attend—and this percentage is one of the best—if not the best, of any of the state medical associations.

Such attendance at the Annual Meeting wasn't always the case. In 1839, a group of Kentucky physicians, calling themselves "The Medical Association of Northeastern Kentucky", met in Washington, and resolved to hold a convention in Frankfort—on the second Monday in January, 1841—for the purpose of organizing a state medical society. On that date in 1841, 69 physicians met in Frankfort and established the "State Medical Society of Kentucky." Officers were elected and a constitution and bylaws adopted. The scientific program consisted of a paper given by James C. Cross, M.D., entitled, "Geology", and another by Daniel Drake, M.D., entitled, "A Memoir on the Disease, Called by the People—Trembles", and the "Sick-Stomach, Or Milk-Sickness." Unfortunately, the following year, on January 12, 1842, not enough physicians showed up to hold a meeting; apparently, not even the elected officers of the society appeared. Finally, on October 1, 1851, 39 physicians met in Frankfort and organized the Kentucky State Medical Society. The proceedings of that first Annual Meeting were published—as were those of the second meeting held in Louisville, October 20, 1852. Lunsford P. Yandell, Sr., M.D., complained about the poor attendance at the third Annual Meeting, which was in Lexington on October of 1853. The Associational meeting of 1868 was held in Lebanon—and one of the scientific papers that attracted the most attention was given by John D. Jackson, M.D., of Danville—entitled, "The Innoculability and Transmission of Tuberculosis."

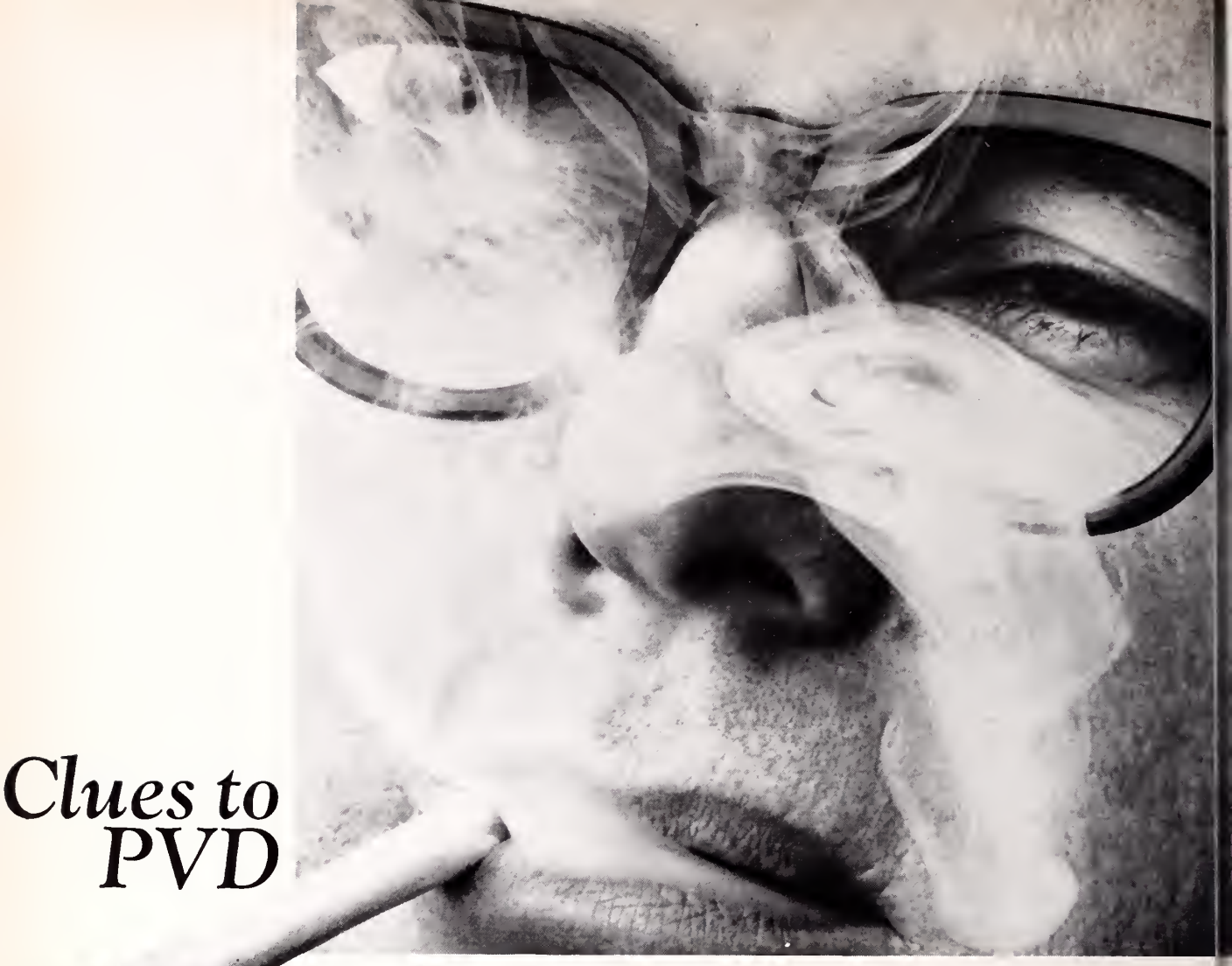
The Annual Meeting now requires large physical accommodations, and much detailed planning in advance. The scientific program alone occupies three days, and this year will offer an excellent and diversified series of subjects—presented by outstanding speakers. In recent years the quality of the scientific programs has been excellent, and this year will be no exception. The program committee, under the chairmanship of Peter Bosomworth, M.D., has done a fine job. Some of the highlights of the program will be panel discussions on: "The Early Diagnosis of Cancer"; "New Trends in Chemotherophy"; "Early Diagnosis of Gynecologic Cancer"; "Obesity"—and others. On Wednesday afternoon something new will be tried—called the "Cracker-barrel Session." This will consist of small, informal group discussions, with each group led by a discussion leader. Fourteen different subjects will be offered to the physicians in this manner—and you may choose the one in which you wish to participate.

New information may be obtained by visiting the exhibits. This year there will be over 70 technical exhibits, and a number of scientific exhibits.

The House of Delegates will meet Monday morning, September 22, and again in the evening of Wednesday, September 24. Any member of KMA may attend these meetings, with only the delegates being allowed to vote on the many issues that are presented and discussed.

Insofar as organized medicine in Kentucky is concerned, the Annual Meeting is the main event of the year. You should be a part of it!

WALTER S. COE, M.D.



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt —bottles of 50.



Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN
depressants. As with all CNS-acting drugs, ca
tion patients against hazardous occupations r
quiring complete mental alertness (*e.g.*, operati
machinery, driving). Though physical and ps
chological dependence have rarely been report
on recommended doses, use caution in a
ministering Librium (chlordiazepoxide hydr
chloride) to known addiction-prone individua
or those who might increase dosage; withdraw
symptoms (including convulsions), followi
discontinuation of the drug and similar to tho
seen with barbiturates, have been reported. U
of any drug in pregnancy, lactation, or in wome
of childbearing age requires that its potenti
benefits be weighed against its possible hazard
As with all anticholinergic drugs, an inhibitir
effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate
limit dosage to smallest effective amount to pr
clude development of ataxia, oversedation
confusion (not more than two capsules per da
initially; increase gradually as needed and tole

or here.



ed). Though generally not recommended, if ombination therapy with other psychotropics eems indicated, carefully consider individual harmacologic effects, particularly in use of po- ntiating drugs such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic function. aradoxical reactions (*e.g.*, excitement, stimula- on and acute rage) have been reported in psy- iatric patients. Employ usual precautions in eatment of anxiety states with evidence of im- ending depression; suicidal tendencies may be resent and protective measures necessary. Vari- ble effects on blood coagulation have been eported very rarely in patients receiving the rug and oral anticoagulants; causal relation- hip has not been established clinically.

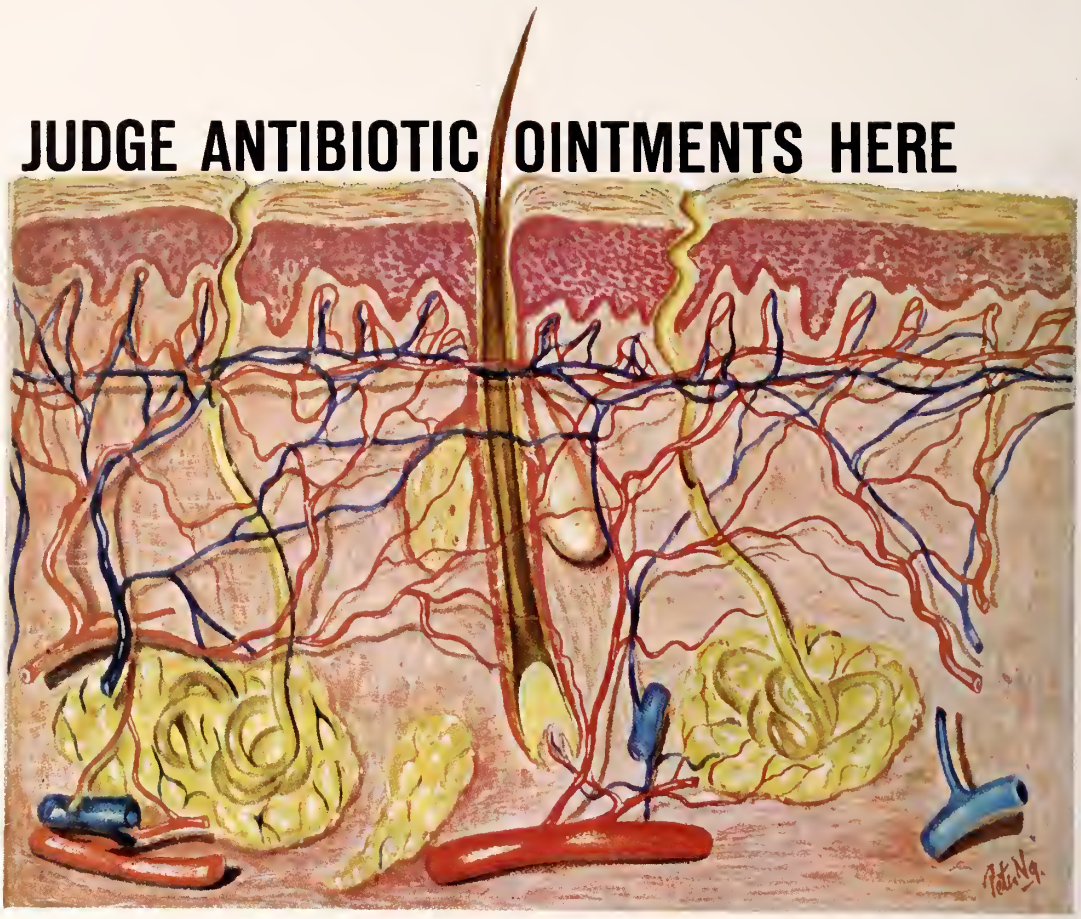
ADVERSE REACTIONS: No side effects or anifestations not seen with either compound lone have been reported with Librax. When hlordiazepoxide hydrochloride is used alone, rowsiness, ataxia and confusion may occur, specially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Index To Annual Meeting Section

KMA Officers for 1968-69 594
District Trustees and Trustee Map 598
Delegates to the KMA House 599
Reference Committee Activity 601
Official Call to Meeting 602
Annual Meeting Special Features 603
Orientation Program 604
1969 Annual Meeting Program Summary 605
Complete Scientific Program of Annual Meeting 606
Alumni Reunions 612
President's Luncheon and Awards 612
Pre-registration Information 613
Technical Exhibits 614
Woman's Auxiliary Program 615

Annual Meeting Section



HENRY B. ASMAN, M.D.
PRESIDENT

KMA OFFICERS

1968

1969



Edwin P. Solomon, M.D.
Vice President

PRESIDENT-ELECT
Walter L. Cawood, M.D.
Ashland

A highlight of the 1969 Annual Meeting will be the installation of Doctor Cawood as president of the Kentucky Medical Association on Wednesday evening, September 24. Elected KMA Trustee for the 13th District in 1964, Doctor Cawood served as chairman of the Board during the 1967-1968 Associational Year, the first year of his second term as a trustee.

Born at Lena Rue in Harlan County, Kentucky in 1921, Doctor Cawood graduated from Hall High School in 1940. He attended Berea College, Eastern Kentucky State Teachers College and the University of Kentucky, graduating from the University of Louisville School of Medicine in 1946. After completing his internship at Nashville General Hospital he served for two years in the Army Medical Corp at Pasadena, California.

Upon his discharge from military service, Doctor Cawood began general practice in Harlan where he remained until 1955. He then spent three years in a radiology residency at Johns Hopkins Hospital. He has practiced radiology in Ashland since 1958.

Active in the affairs of the Boyd County Medical Society and the Kentucky Medical Association, the American Medical Association and the American College of Radiology for many years, Doctor Cawood is well qualified for the office of president to which his fellow KMA members have elected him.

VICE PRESIDENT
Edwin P. Solomon, M.D., Louisville

An active participant in medical affairs at both state and local level, Doctor Solomon, an obstetrician and gynecologist, graduated from Tulane Medical School. He is past president of the Jefferson County Medical Society and the Kentucky and Louisville Obstetrical and Gynecologic Societies and has served on many KMA committees. An assistant professor of obstetrics and gynecology at the University of Louisville School of Medicine, Doctor Solomon is a fellow of the American College of Obstetrics and Gynecology and of the American College of Surgeons and a diplomate of the American Board of Obstetrics and Gynecology.

Secretary and Treasurer

SECRETARY
S. Randolph Scheen, M.D., Louisville

Now serving his second year as KMA secretary, Doctor Scheen, a dermatologist is an instructor in medicine at the University of Louisville School of Medicine and chief of dermatology at St. Joseph's Infirmary. He is a 1953 graduate of the University of Louisville School of Medicine and a member of the American Academy of Dermatology, the Noah Worcester Dermatologic Society and the Alumni Association of the Mayo Foundation.



TREASURER
Keith P. Smith, M.D., Corbin

Doctor Smith has served as KMA treasurer since 1963 and is a former vice president and chairman of the Board of Trustees. A 1936 graduate of the University of Louisville School of Medicine, he is a past president and vice president of the Kentucky Academy of General Practice. He has practiced for a number of years in Corbin where he was first chief of staff of the Corbin Municipal Hospital.



Journal Editors

EDITOR
Walter S. Coe, M.D., Louisville

Elected this year to his second two-year term as editor of *The Journal,* Doctor Coe was recently named president-elect of the Jefferson County Medical Society. A 1943 graduate of the University of Louisville School of Medicine, he is an associate clinical professor of medicine at that institution. He is past president of the Kentucky, Louisville and Jefferson County Heart Associations.



ASSOCIATE EDITOR
Sam A. Overstreet, M.D., Louisville

Doctor Overstreet served as president of the Kentucky Medical Association during its Centennial year 1950-51 and is a former *Journal* editor, a position in which he served for eight years. He is a 1923 graduate of the University of Louisville School of Medicine, a member of the State Board of Health, the Southern Medical Association and the American College of Physicians.



ASSISTANT EDITOR
Walter I. Hume, Jr., M.D., Louisville

Now serving as president of the Jefferson County Medical Society, Doctor Hume has been very active in committee work both in the Society and in the Kentucky Medical Association. An assistant clinical professor of surgery at the University of Louisville School of Medicine, he is a 1949 graduate of Harvard Medical School.



AMA Delegate
J. Thomas Giannini, M.D., Louisville

A 1938 graduate of the University of Louisville School of Medicine, Doctor Giannini is a fellow of the American Society of Plastic and Reconstructive Surgeons. He has served as a delegate to the AMA since 1963 and was previously an alternate delegate. He has also served KMA as a delegate from Jefferson County and as chairman of the Scientific Exhibits Committee.



AMA Delegates

John C. Quertermous, M.D., Murray

An internist practicing in Murray since 1950, Doctor Quertermous has been an AMA delegate since 1963 and serves as chairman of the KEMPAC Board. He is a 1942 graduate of the University of Louisville School of Medicine and a past president of the Calloway County Medical Society. He is a former chairman of the KMA Council on Legislative Activities for national affairs.



Charles C. Rutledge, M.D., Hazard

Doctor Rutledge, a former alternate delegate, has served as an AMA delegate since 1965. A surgeon, he graduated from the University of Louisville School of Medicine in 1946 and has practiced in Hazard since 1955. He is a member of the Kentucky Surgical Society and the Southern Medical Association and a fellow of the American College of Surgeons.



New Trustees

Thornton E. Bryan, Jr., M.D., Cadiz

A 1954 graduate of the University of Louisville School of Medicine, Doctor Bryan has practiced in Cadiz since 1955. He is a member of the KMA Executive Committee, Plans and Development committee, a past president of the Kentucky Academy of General Practice, and president of the Trigg County Hospital staff.

C. C. Lowry, M.D., Murray

Doctor Lowry served as vice president of KMA for the Western District during the 1965-66 Associational year. A surgeon, he graduated from Vanderbilt Medical School in 1943 and has practiced in Murray since 1952. He is a fellow of the American College of Surgeons and holds membership in the Southeastern Surgical Congress and the Kentucky Surgical Society.

W. Bruce Hamilton, M.D., Shepherdsville

In the two years preceding his election as a trustee, Doctor Hamilton, a 1953 graduate of the University of Louisville School of Medicine, served as chairman of the KMA By-Laws Committee. He was president of the Bullitt County Medical Society in 1968 and is a member of the Bullitt County Board of Health and the Kentucky Academy of General Practice.

Robert N. McLeod, Jr., M.D., Somerset

Doctor McLeod, a pediatrician, graduated from the University of Pennsylvania School of Medicine in 1945 and has practiced in Somerset since 1950. He served for five years as chairman of the KMA Committee on Neo-Natal Mortality and for three years as a member of the Board of Consultants for *The KMA Journal.* He is past president of the Kentucky Pediatric Society and the Pulaski County Medical Association.

Paul E. Holbrook, M.D., Ashland

Elected to fill the unexpired term of Walter L. Cawood, M.D., Ashland, KMA president-elect, Doctor Holbrook is a 1938 graduate of the University of Louisville School of Medicine. An internist, he has practiced in Ashland since 1945.

Election of Trustees and Alternate Trustees

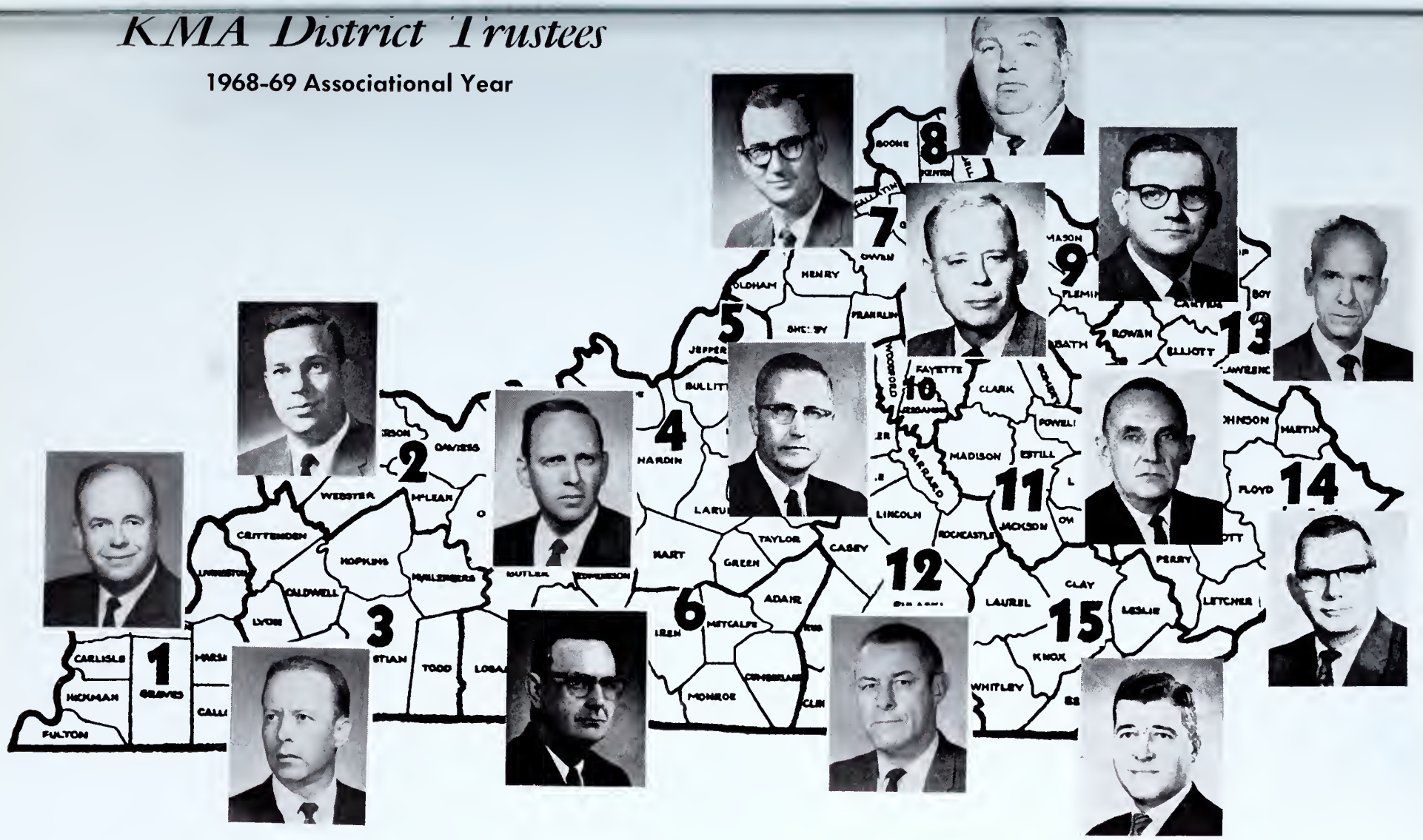
Five district trustees and five alternate trustees will be elected by **The House of Delegates** at its second session, Wednesday, September 24. Nominations will be made by the delegates from the electing districts at a meeting following the first session of the House on Monday, September 22. The committee will report its nominees at the close of the first scientific session on Tuesday, September 23. Nominations may be made from the floor at the final session of the House Wednesday evening, September 24. The delegates will consider and act upon all nominations at this final session.

Districts electing trustees for three-year terms are: **FIFTH DISTRICT** (incumbent George A. Sehlinger, M.D., Louisville); **SIXTH DISTRICT** (incumbent Rex E. Hays, M.D., Glasgow); **EIGHTH DISTRICT** (incumbent Lee C. Hess, M.D., Florence); **ELEVENTH DISTRICT** (incumbent Douglas H. Jenkins, M.D., Richmond); **FIFTEENTH DISTRICT** (incumbent E. C. Seeley, M.D., London.) All are eligible for re-election with the exception of Doctor Hayes who has served two full terms.

Districts electing alternate trustees are the same as those electing trustees. Incumbents are W. Fielding Rubel, M.D., Louisville; James O. Willoughby, M.D., Bowling Green; Donald K. Dudderar, M.D., Newport; Hugh Mahaffey, M.D., Richmond; and Harold L. Bushey, M.D., Barbourville, respectively. All five alternate trustees are eligible for re-election.

KMA District Trustees

1968-69 Associational Year



1. C. C. LOWRY — Murray
2. WILLIAM W. HALL* — Owensboro
3. THORNTON E. BRYAN, JR.* — Cadiz
4. W. BRUCE HAMILTON — Shepherdsville
5. GEORGE A. SEHLINGER* — Louisville
6. REX E. HAYES — Glasgow
7. DONALD CHATHAM — Shelbyville
8. LEE C. HESS*† — Florence
9. J. CAMPBELL CANTRILL — Georgetown
10. ANDREW M. MOORE — Lexington
11. DOUGLAS H. JENKINS — Richmond
12. ROBERT N. McLEOD, JR. — Somerset
13. PAUL E. HOLBROOK — Ashland
14. BALLARD W. CASSADY — Pikeville
15. E. C. SEELEY — London

†Chairman of the Board
**Member of the Executive Committee*

Officers of the House of Delegates

SPEAKER
Richard F. Greathouse, M.D., Louisville



Now serving his second term as speaker of the House, Doctor Greathouse is a former vice-speaker and delegate from the Jefferson County Medical Society. He has served as secretary-treasurer of KEMPAC and is past president of the Louisville Pediatric Society. He is a 1951 graduate of the University of Louisville School of Medicine where he is an assistant clinical professor of pediatrics.

VICE-SPEAKER
Carl C. Cooper, M.D., Bedford



A former KMA vice president and alternate delegate to the AMA, Doctor Cooper is serving his second term as vice-speaker of the House. He has served on many KMA committees and is a past vice-president of the Kentucky Academy of General Practice. Doctor Cooper graduated from the University of Louisville School of Medicine in 1952. He is a member of the American Academy of General Practice.

KMA Delegates

ADAIR
Oris Aaron, Columbia

ALLEN
Earl P. Oliver, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
Glenn D. Baird, Bandana

BARREN
W. H. Bryant, Glasgow

BATH

BELL
Charles B. Stacy, Pineville
Kenneth W. Smith, Middlesboro

BOONE
Glenn F. Baird, Florence

BOURBON
Richard Wever, Paris

BOYD
John Harrison, Ashland

BOYLE
John M. Baird, Danville

BRACKEN
James Stevenson, Brooksville

BREATHITT
F. C. Lewis, Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT
Patrick Murphy, Lebanon Jct.

BUTLER
D. G. Miller, Jr., Morgantown

CALDWELL

CALLOWAY
Hugh Houston, Murray

CAMBELL-KENTON
Carl J. Brueggemann, Covington
Donald K. Dudderar, Newport
W. V. Pierce, Covington
Donald Janney, Covington
Louis J. Nutini, Erlanger
Thomas L. Heavern, Jr., Highland Hts.

CARLISLE
J. T. O'Neill, Arlington

CARROLL
E. S. Weaver, Carrollton

CARTER

CASEY
Lewis E. Wesley, Liberty

CHRISTIAN
W. Faxon Payne, Hopkinsville
James B. Cox, Hopkinsville

CLARK

CLAY
W. E. Becknell, Manchester

CLINTON
Earnest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
Joseph Schickel, Burkesville

DAVIESS
Coy Ball, Owensboro
J. C. Stiles, Owensboro
J. S. Oldham, Owensboro

EDMONSON
S. E. Farmer, Brownsville

ELLIOTT
Brown L. Adkins, Sandy Hook

ESTILL
Charles E. Terry, Irvine

FAYETTE
John F. Berry, Jr., Lexington
Leslie W. Blakey, Lexington
M. Cary Blaydes, Lexington
Peter P. Bosomworth, Lexington
N. Lewis Bosworth, Lexington
Thomson R. Bryant, Lexington
Winston L. Burke, Lexington
David A. Hull, Lexington
Richard D. Floyd, Lexington
Richard F. Hench, Lexington
Bush A. Hunter, Lexington
Carl H. Scott, Lexington
Ben C. Stigall, Lexington

FLEMING
S. W. Gehring, Flemingsburg

FLOYD
Lowell Martin, Martin

FRANKLIN
Sandford L. Weiler, Frankfort
B. B. Baughman, Frankfort

FULTON
Glynn F. Bushart, Fulton

GALLATIN
John D. Fielding, Jr., Warsaw

GARRARD
O. S. Playforth, Lancaster

GRANT
Darl B. Shipp, Dry Ridge

GRAVES
Henry B. Keister, Mayfield

GRAYSON
P. A. O'Neill, Leitchfield

GREEN
Robert Simmons, Greensburg

GREENUP

HANCOCK
Glenn Richards, Lewisport

HARDIN
Clyde Brassfield, Elizabethtown

HARLAN
Henry Evans, Harlan
R. Smith Howard, Harlan

HARRISON
Wilbur H. Wilson, Cynthiana

HART
Keene M. Hill, Jr., Horse Cave

HENDERSON
Kenneth Eblen, Henderson
Charles C. Kissinger, Henderson

HENRY
Robert Houston, Eminence

HICKMAN
C. J. Mills, Clinton

HOPKINS
Loman E. Trover, Madisonville
Faull S. Trover, Madisonville

JACKSON
Donald L. Peterson, McKee

JEFFERSON
Ralph M. Denham, Louisville
Harold G. Eskind, Louisville
Roy A. Martin, Louisville
Robert L. McClendon, Louisville
F. Albert Olash, Louisville
Bernard I. Popham, Louisville
W. Fielding Rubel, Louisville
S. Randolph Scheen, Louisville
Robert C. Tate, Louisville
Robert S. Tillett, Louisville
James G. Baker, Louisville
Frank M. Gaines, Jr., Louisville
R. F. Greathouse, Louisville
Cecil L. Grumbles, Louisville
N. I. Handelman, Louisville
Edward N. Maxwell, Louisville
Herman R. Moore, Jr., Louisville
Carroll H. Robie, Louisville
Charles C. Smith, Jr., Louisville
Donn L. Smith, Louisville
John D. Allen, Jr., Louisville
William H. Bizot, Louisville
Glenn W. Bryant, Louisville
Peter C. Campbell, Jr., Louisville
Elbert G. Christian, Louisville
Fred C. Coy, Jr., Louisville
Morgan R. Colbert, Louisville
John H. Doyle, Louisville
Charles M. Hargadon, Louisville
Clyde T. Moore, Louisville
Charles R. Oberst, Louisville
John L. Wolford, Louisville

JESSAMINE
J. Sankey Williams, Nicholasville

JOHNSON
Glenn R. Powell, Paintsville

KNOTT
Gene T. Watts, Hindman

KNOX
Harold L. Bushey, Barbourville

LARUE
Marion Douglass, Jr., Magnolia

LAUREL
John B. Rypstra, London

LAWRENCE
William J. McNabb, Louisa

LEE

LESLIE
Mary Pauline Fox, Hyden

LETCHER
Jim B. Tolliver, Whitesburg

LEWIS

LINCOLN
Giles L. Stephens, Stanford

LIVINGSTON

LOGAN

LYON
R. H. Hyde, Eddyville

McCRACKEN
Burton Haley, Paducah
Walter Johnson, Paducah
W. Eugene Sloan, Paducah

McCREARY
H. A. Perry, Whitley City

McLEAN
Everett S. Coleman, Sacramento

MADISON

MAGOFFIN

MARION

MARSHALL
Keith Ellis, Benton

MARTIN
Raymond Wells, Inez

MASON
William Savage, Maysville

MEADE

MENIFEE
Donald L. Graves, Frenchburg

MERCER
Frank Whalen, Harrodsburg

METCALFE
L. P. Emberton, Edmonton

MONROE
J. Jack Martin, Tompkinsville

MONTGOMERY
Robert J. Salisbury, Mt. Sterling

MORGAN
Alec Spencer, West Liberty

MUHLENBERG
Mark A. Judge, Central City

NELSON
Kenneth L. Stinnette, Bardstown

NICHOLAS
W. R. Kingsolver, Carlisle

OHIO

OLDHAM
Burl Mack, Pewee Valley

OWEN
O. A. Cull, Owenton

OWSLEY
Mildred B. Gabbard, Booneville

PENDLETON
William M. Townsend, Falmouth

PERRY
Keith Cameron, Ary

PIKE
Harvey A. Page, Pikeville
Max P. Jones, Pikeville

POWELL

PULASKI
Stephen B. Kelley, Somerset
John P. Hill, Somerset

ROBERTSON

ROCKCASTLE
George H. Griffith, Mt. Vernon

ROWAN

RUSSELL
James E. Monin, Jamestown

SCOTT
R. Kendall Brown, Georgetown

SHELBY
M. D. Klein, Shelbyville

SIMPSON
Douglas R. Alvey, Franklin

SPENCER
M. H. Skaggs, Taylorsville

TAYLOR
H. F. Chambers, Campbellsville

TODD
Ralph D. Lynn, Elkton

TRIGG
Thornton Bryan, Jr., Cadiz

TRIMBLE
Carl Cooper, Bedford

UNION
Wallas N. Bell, Sturgis

WARREN
Paul J. Parks, Bowling Green
James O. Willoughby, Bowling Green

WASHINGTON
Richard A. Hamilton, Springfield

WAYNE
John W. Simmons, Monticello
(Continued on page 602)

Reference Committee Activity

All officers' and committees' reports and resolutions will be referred to one of six reference committees by Speaker Richard F. Greathouse, M.D., Louisville **at the first meeting of the KMA House of Delegates at 9 a.m. Monday, September 22.** Reference committee chairmen will meet for briefing sessions at 12:30 p.m. Monday in Room 317, Kentucky Hotel. **Reference committees will meet on the mezzanine floor of the Kentucky Hotel at 2 p.m. Monday, September 22 and any KMA member wishing to testify on any resolution or report is urged to be present.** In order to permit all who wish to speak to be heard, these open sessions will last at least one hour. The committees will go into executive sessions following the open hearings to study the reports, review the testimony and write their reports to the House.

The committees' recommendations will be presented **at the final session of the House, Wednesday night, September 24,** in the Terrace Room, Kentucky Hotel. Listed below are the reference committees appointed by Doctor Greathouse to serve during the 1969 session.

1969 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1
Parlor B

Lewis Bosworth, M.D., Lexington, Chairman
Harold Bushey, M.D., Barbourville
Burton Haley, M.D., Paducah
Thomas L. Heavern, M.D., Highland Heights
Bernard Popham, M.D., Louisville

REFERENCE COMMITTEE NO. 2
Room 203

Donn L. Smith, M.D., Louisville, Chairman
Max Jones, M.D., Pikeville
Glen Richards, M.D., Lewisport
Carl Scott, M.D., Lexington
Faull Trover, M.D., Madisonville

REFERENCE COMMITTEE NO. 3
Room 204

James Cox, M.D., Hopkinsville, Chairman
Cecil Grumbles, M.D., Louisville
David Hull, M.D., Lexington
John S. Oldham, M.D., Owensboro
Charles B. Stacy, M.D., Pineville

REFERENCE COMMITTEE NO. 4
Parlor A

Ed Maxwell, M.D., Louisville, Chairman
Carl Brueggemann, M.D., Covington
John Hill, M.D., Somerset
Hugh Houston, M.D., Murray
Robert Houston, M.D., Eminence

REFERENCE COMMITTEE NO. 5
Parlor C

Paul Parks, M.D., Bowling Green, Chairman
Glenn Bryant, M.D., Louisville
John D. Fielding, M.D., Warsaw
Lowell Martin, M.D., Martin
Richard McElvin, M.D., Lexington

REFERENCE COMMITTEE NO. 6
Parlor D

John Baird, M.D., Danville, Chairman
John Berry, M.D., Lexington
Harold Eskind, M.D., Louisville
Mildred Gabbard, M.D., Booneville
John Rypstra, M.D., London

OFFICIAL CALL
KMA Annual Meeting

To the officers and members of the component county medical societies of the Kentucky Medical Association.

Meeting Place

The Annual Meeting of the KMA will convene on Tuesday, Wednesday and Thursday, September 23, 24 and 25, at Convention Center, Louisville. The first general session will be called to order at 8:50 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m., Monday, September 22. The second regular business session will begin at 7 p.m., Wednesday, September 24. A subscription dinner will be served to the delegates preceding the session at 6 p.m. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

Registration

The registration desk will open at the Terrace Room of the Kentucky Hotel at 8 a.m., Monday, September 22, and at 5:30 p.m., Wednesday, September 24. It will be open in the technical exhibit hall of Convention Center from 8 a.m. to 5 p.m. Tuesday, Wednesday and Thursday, September 23-25.

Lung Cancer Screening Booth Scheduled For KMA Meeting

A Lung Cancer Screening Booth will be available to doctors this year at the Annual Meeting. The booth, sponsored by the Kentucky Division of the American Cancer Society, will be located in the main auditorium of Convention Center.

Cytotechnologists will collect sputum samples which will be processed and scanned for the presence of atypical cells. Results of screening will be sent to the physician on whom the study was performed.

All those attending are urged to take advantage of this opportunity.

REGISTRATION INFORMATION

A Registration Booth will be located in the north end of the Convention Hall (in the Technical Exhibit Hall) throughout the Annual Meeting. The booth will open at 8 a.m. Tuesday, Wednesday and Thursday, September 23, 24 and 25.

Please wear your badge at all times while attending the meeting.

House To Elect New KMA Officers For 1969-70 Associational Year

The House of Delegates will elect the KMA officers for the 1969-70 Associational year at the close of its final session Wednesday evening, September 24. Officers to be selected by the House are:

President-Elect (Western) One Year

Vice President (Eastern) One Year

***Secretary (S. Randolph Sheen, M.D., Louisville, incumbent) Three Years**

***Treasurer (Keith P. Smith, M.D., Corbin, incumbent) Three Years**

***AMA Delegates (John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard, incumbents) Two Years**

***AMA Alternate Delegates (Daryl P. Harvey, M.D., Glasgow and David B. Stevens, M.D. Lexington, incumbents) Two Years**

**Eligible for re-election*

Emergency Messages Transferred Through 584-2201 at Meeting

A Message Center will be set up during the Annual Meeting where you may be reached in case of an emergency or for routine messages. The number is (Area Code 502) 584-2201. The Message Center will be located in the center of the Technical Exhibit Hall at Convention Center and will be staffed at all times by trained employees of South Central Bell.

Only emergency calls will be posted on the blackboard in the entrance lobby of Convention Center and in the Scientific Assembly Hall. All other messages will be kept on file at the Message Center until you call for them; so please check this desk frequently.

Due to the arrangement of facilities for the meetings, paging of individual physicians will not be possible.

It will be possible to locate other physicians through the Message Center by calling 584-2201 and asking that your message be delivered.

The Kentucky Hotel phone number is 587-1181. If you are attending the meetings of the House of Delegates, have your calls directed to the Terrace Room. When you receive a call your name will be posted on the blackboard at the front of the room.

You are urged to make use of the Message Center which is located conveniently and efficiently for the transfer of messages. Be sure to leave these phone numbers at your home, office and hospital.

(Continued from page 600)

WEBSTER

WHITLEY

Roemer D. Pitman, Williamsburg

WOLFE

WOODFORD

Francis Willey, Versailles

Annual Meeting



Special Features

The Kentucky Hotel
KMA Annual Meeting Headquarters

SCIENTIFIC PROGRAM September 23, 24 and 25 will feature panel discussions of timely medical topics by prominent, nationally recognized physicians. Themes will include "Cancer," "Drugs," "Transplants," "Atherosclerosis," "Obesity," and "School Health." A new "Crackerbarrel Session" will be introduced at the September 24 afternoon session.

SIXTEEN SPECIALTY GROUPS have scheduled meetings on the afternoons of September 23 and 25. KMA members may attend any of these meetings in which they are interested.

THE HOUSE OF DELEGATES, top policy-making body of the Association, will meet at 9 a.m. Monday, September 22, and at 7 p.m., Wednesday, September 24 in the Terrace Room of the Kentucky Hotel. New KMA officers will be elected at the second session.

THE PRESIDENT'S LUNCHEON guest speaker will be M. Stanton Evans, Indnanapolis, Indiana, editor of the *Indianapolis News*. Mr. Evans will discuss "The Future of Freedom." Beginning at 11:50 a.m. Wednesday, September 24 in the Flag Room of the Kentucky Hotel, the luncheon will also feature the presentation of KMA's three top awards.

SEVENTY-FIVE TECHNICAL EXHIBITS of a variety of medical products and services will be on display in Convention Center near the scientific session Assembly Hall. Members will have the opportunity to gain the latest information about recent advances in many fields of interest.

ALUMNI REUNIONS for the five-year classes of the University of Louisville School of Medicine are planned.

THE WOMAN'S AUXILIARY to KMA will hold its 47th Annual Convention September 22, 23 and 24 at the Kentucky Hotel. Business sessions and special entertainment have been scheduled.

New KMA Members To Be Offered Ninth Orientation Course Sept. 22

Approximately 100 new KMA members will have an opportunity to take the Ninth KMA Orientation course, which will be held in the Mirror Room of the Kentucky Hotel on Monday, September 22, just prior to the opening of the 1969 KMA Annual Meeting.

The members of the KMA Communication and Health Education Committee have spent much time in preparing an outstanding program designed to better equip new KMA members in meeting present-day responsibilities as a citizen and as a physician. The informative and fast-moving session will begin promptly at 8:30 a.m., following registration at 8:00 a.m., and will adjourn by 12:30 p.m.

Letters of invitation are being sent to those KMA members who have joined the Association during the past two years and have not as yet attended an orientation program. Any KMA member, whether he receives an invitation or not, is most welcome to attend the course. Following is the program to be presented at the Ninth Orientation Course on Monday, September 22.

Ninth KMA Orientation Program

N. Lewis Bosworth, M.D., Lexington
Moderator

8:00 a.m. **Registration**

8:30 a.m. **Welcome and Introduction**
Henry B. Asman, M.D., Louisville
KMA President

8:35 a.m. **"The Wife's Role in Organized Medicine"**
Mrs. William McBeath, Lexington
President, Woman's Auxiliary to KMA

Structure-Function-Policies in Organized Medicine

8:50 a.m. **"County Medical Society"**
Walter Johnson, M.D., Paducah
Past President
McCracken County Medical Society

9:05 a.m. **"Kentucky Medical Association"**
S. Randolph Scheen, M.D., Louisville
KMA Secretary

9:20 a.m. **"American Medical Association"**
Robert C. Long, M.D., Louisville
Member, AMA Board of Trustees

9:35 a.m. **"Community Relations"**
Charles Rutledge, M.D., Hazard
Delegate to AMA

9:55 a.m. **"Health Insurance" (Blue Cross-Blue Shield)**
J. Ed McConnell, Louisville
President
Blue Cross Hospital Plan, Inc.

10:10 a.m. **"Health Insurance" (Commercial)**
Francis J. Batridge
Metropolitan Life Insurance Company

10:25 a.m. **COFFEE BREAK**

10:40 a.m. **"Cults"**
David B. Stevens, M.D., Lexington
Chairman, KMA Cults Committee

10:55 a.m. **"Medical Ethics"**
Clyde C. Sparks, M.D., Ashland
KMA Past President

11:15 a.m. **"Medico-Legal Aspects"**
E. Gaines Davis, Jr., Frankfort
KMA Legal Counsel

11:35 a.m. **"Medico-Press Relations"**
Charles Harrison, Louisville
Associate News Director
WAVE-TV, & AM

11:50 a.m. **"The National Scene for Medical Legislation"**
John C. Quertermous, M.D., Murray
Chairman, KEMPAC Board of Directors

12:05 p.m. **"State Legislation and the Key Man System"**
Fred C. Rainey, M.D., Elizabethtown
Chairman for State Affairs
KMA Committee on Legislative Activities

12:15 p.m. **"The Physician's Role in Legislation and Politics"**
Hoyt D. Gardner, M.D., Louisville
Secretary-Treasurer
American Medical Political Action Committee

Nominating Committee To Hold Open Meeting September 22

The KMA Nominating Committee will hold an open meeting following the close of the first session of the House of Delegates Monday, September 22, at the alcove in the Terrace Room of the Kentucky Hotel.

Any KMA member may confer with the committee during this meeting. Final recommendations of the committee will be made at the end of the first scientific session Tuesday morning, September 23.

The House of Delegates will vote on the nominees at the close of its second session, September 24. At this session nominations may be made from the floor.

Fred C. Rainey, M.D., Elizabethtown is chairman of the Nominating Committee. Members are Joseph R. Miller, M.D., Benton; Paul J. Parks, M.D., Bowling Green; William P. VonderHaar, M.D., Louisville; and J. Sankey Williams, M.D., Nicholasville.

KEMPAC Seminar Planned Sept. 22

The annual KEMPAC Seminar, held Monday, September 22 in the Grand Ballroom of the Seelbach Hotel in Louisville, will open with a social hour at 6 p.m., followed by dinner, a program featuring three outstanding speakers, and dancing. Complete details on the event will be presented in the September issue of The Journal.

1969 Annual Meeting Program Summary

The Kentucky Medical Association

September 20, 21, 22, 23, 24, and 25

Louisville

SATURDAY, SEPTEMBER 20

6:30 p.m. Dinner Meeting, Board of Directors, Ky. Physicians Mutual Pendennis Club

SUNDAY, SEPTEMBER 21

12:30 p.m. Luncheon Meeting, KMA Board of Trustees Parlor A, Kentucky Hotel

MONDAY, SEPTEMBER 22

8:30 a.m. Orientation Program, New KMA Members Mirror Room, Kentucky Hotel
9:00 a.m. First Meeting, KMA House of Delegates Terrace Room, Kentucky Hotel
12:30 p.m. Luncheon for Reference Committee Chairmen Room 317, Kentucky Hotel
2:00 p.m. Reference Committee Meetings Parlors A, B, C, D—Rooms 203 & 204, Kentucky Hotel
6:00 p.m. KEMPAC Reception, Banquet and Seminar Grand Ballroom, Seelbach Hotel

TUESDAY, SEPTEMBER 23

8:50 a.m. Opening Ceremonies Scientific Assembly Hall, Convention Center
9:00 a.m. Registration Technical Exhibit Hall, Convention Center
9:00 a.m. First Scientific Session Scientific Assembly Hall, Convention Center
12:00 noon Board of Trustees Luncheon & Meeting Parlor A, Kentucky Hotel
2:00 p.m. Specialty Group Sessions, Convention Center (*Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session at this time. See pages 606-608 in program*).

WEDNESDAY, SEPTEMBER 24

9:00 a.m. Second Scientific Session Scientific Assembly Hall, Convention Center
11:50 a.m. President's Luncheon Flag Room, Kentucky Hotel
2:00 p.m. Third Scientific Session Scientific Assembly Hall, Convention Center
5:00 p.m. Meeting, Board of Trustees Parlor B—Dinner at 6:00, Parlor A, Kentucky Hotel
6:00 p.m. Subscription Dinner and Meeting, House of Delegates Terrace Room, Kentucky Hotel

THURSDAY, SEPTEMBER 25

9:00 a.m. Fourth Scientific Session Scientific Assembly Hall, Convention Center
12:00 noon Board of Trustees Luncheon and Afternoon Meetings Parlor A, Kentucky Hotel
2:00 p.m. Specialty Group Sessions, Convention Center (*Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session. See page 610-611 in program*).

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting Scientific and Technical Exhibits.

(Full Scientific Program Starts on page 606)

The Kentucky Medical Association

SCIENTIFIC PROGRAM

Lewis S. McMurtry Memorial Meeting

Convention Center, Louisville

TUESDAY, SEPTEMBER 23
MORNING SESSION

General Session

Henry B. Asman, M.D., Louisville, KMA President Presiding

8:50 **Opening Ceremonies**

9:00 **PANEL DISCUSSION "The Early Diagnosis of Cancer"**
William Jewell, M.D., Lexington, Moderator
Gilbert S. Campbell, M.D., Little Rock, Ark.
Richard K. Winkelmann, M.D., Rochester, Minn.
William Christopherson, M.D., Louisville
Willet F. Whitmore, Jr., M.D., New York, N.Y.

10:00 **Intermission to Visit Exhibits**

10:30 **PANEL DISCUSSION: "New Trends in Chemotherapy"**
William Jewell, M.D., Lexington, Moderator
Richard K. Winkelmann, M.D., Rochester, Minn.
M. Eugene Lahey, M.D., Salt Lake City, Utah
Ricardo R. Fuste, M.D., Memphis, Tenn.
Willet F. Whitmore, Jr., M.D., New York, N.Y.

11:30 **President's Address**
Henry B. Asman, M.D., Louisville

TUESDAY, SEPTEMBER 23
AFTERNOON SESSION

Eight Specialty Group Meetings

(The scientific programs of eight specialty groups, beginning at 2 p.m., will feature prominent guest speakers from throughout the country. All KMA members are invited to attend the specialty group meetings of their choice. There will be no general scientific session at this time.)

Kentucky Society of Anesthesiologists

Room 205, Convention Center

2:00 **"Cardiac Arrhythmias, Prescription of"**
Alon P. Winnie, M.D., Chicago, Ill.

3:00 **Intermission to Visit Exhibits**

3:30 **Business Meeting**

3:50 **"Anesthesiology and Emergency Medical Care"**
Lloyd F. Redick, M.D., Lexington

GILBERT S. CAMPBELL, M.D.
Little Rock, Arkansas



Professor and chairman, department of surgery, chief of thoracic surgery division, University of Arkansas Medical Center. M.D., 1946, University of Virginia. M.S., 1949, Ph.D., 1954, University of Minnesota. Fellow, American College of Surgeons. Member, American Association for Advancement of Science, American Association for Thoracic Surgery, Arkansas, Southwestern, Southern and American Surgical Societies.

RICHARD K. WINKELMANN, M.D.

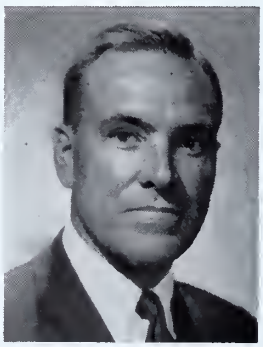
Rochester, Minnesota



Professor of dermatology and anatomy, University of Minnesota, staff, Mayo Clinic. M.D., 1948, Marquette University. Ph.D., 1956, University of Minnesota. Atomic Energy Commission Fellow in Medicine, 1949-51.

WILLET F. WHITMORE, JR., M.D.

New York, New York



Clinical professor of surgery (urology), Cornell University Medical College, attending surgeon (urology), New York Hospital. M.D., 1942, Cornell University Medical College. Fellow, American College of Surgeons. Consultant to National Cancer Institute. Member, New York, American Urological Association. Honorary member, British, Mexico, Peruvian, Colombian, Venezuelan Urological Societies.

Kentucky Chapter, American College of Chest Physicians

Room 104, Convention Center

2:00 **"Black Lung"**
G.N. Combs, M.D., Pikeville
Porter Mayo, M.D., Lexington

2:15 **"Radiology of Chest and Lung Scanning"**
Arthur Lieber, M.D., Lexington
J.T. Ling, M.D., Louisville

2:30 **"Cardiology"**
Henry Post, M.D., Louisville
Frank Moore, M.D., Bowling Green

2:45 **"E.K.G."**
Armond T. Gordon, M.D., Louisville
Ferrell C. Lowery, Jr., M.D., Louisville

3:00 **Intermission to Visit Exhibits**

3:30 **"Evaluation and Rehabilitation of Emphysematous Patients"**
Tom Stephenson, M.D., Louisville
Israel Muss, M.D., Louisville

Kentucky Dermatological Society

General Hospital

2:00 **"Dermatology Clinic and Discussion"**
William E. McDaniel, M.D., Lexington, Moderator

3:00 **Intermission to Visit Exhibits**

3:30 **"General Discussion of Cases Presented"**
Richard K. Winkelmann, M.D., Rochester, Minn.

Kentucky Obstetrical and Gynecologic Society

Room 101, Convention Center

2:00 **PANEL ON FETAL MONITORING**
"Chemical Monitoring"
J.W. Greene, Jr., M.D., Lexington
"Mechanical and Electronic Monitoring"
P.V. Dilts, Jr., M.D., Lexington
Warren H. Pearse, M.D., Omaha, Neb.

3:00 **Intermission to Visit Exhibits**

3:30 **PANEL ON EARLY DIAGNOSIS OF GYNECOLOGIC CANCER**
"Cytodiagnosis"
D.N. Tweeddale, M.D., Lexington
"Other Diagnostic Methods"
F.H. Catron, M.D., Lexington
Warren H. Pearse, M.D., Omaha, Neb.

Kentucky Chapter, American Academy of Pediatrics

Assembly Hall, Convention Center

2:00 **"Choice of Iron Compounds in the Treatment of Iron Deficiency Anemia"**
Eugene Lahey, M.D., Salt Lake City, Utah

2:30 **"Therapeutic Management of Collagen Diseases"**
Nancy Holland, M.D., Lexington

3:00 **Intermission to Visit Exhibits**

3:30 **"Cow's Milk Induced Enteric Blood Loss as a Cause of Iron Deficiency Anemia"**
Eugene Lahey, M.D., Salt Lake City, Utah.

4:00 **"Diagnosis and Management of the Hemolytic Anemias"**
Phillip Holland, M.D., Lexington

M. EUGENE LAHEY, M.D.

Salt Lake City, Utah

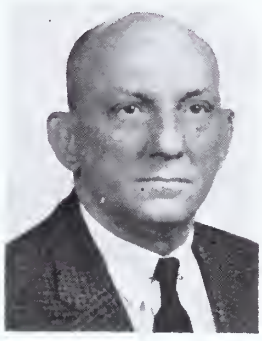


Professor and head, department of pediatrics, University of Utah, M.D., 1943, St. Louis University. Past president, Western Society for Pediatrics Research. Editorial Board, The Journal of Pediatrics. Member, Medical Advisory Board, The Leukemia Society, U.S. Pharmacopeia Scope Panel on Pediatrics. Author or co-author of 48 papers relating to pediatrics.

RICARDO R. FUSTE, M.D.

Memphis, Tennessee

Radiatherapist at Methodist Hospital. M.D., 1941, University of Havana Medical School. Previous practice in surgical pathalogy and radiatherapy in Cuba. Former member of many societies in Cuba and Memphis Roentgen Society. Authar or co-arthor of several papers an the study of cancer.



ALON P. WINNIE, M.D.

Chicago, Illinois



Assistant professar of anesthesialagy, Northwestern University Medical School. M.D., 1958, Northwestern University. Fellow, American College of Anesthesiologists, President, Chicago Sosiety af Anesthesialogists. Editar, ISA Bulletin. Member, International Anesthesia Research Society, American Therapeutic Society.

Kentucky Psychiatric Association
Room 204, Convention Center

2:00 "Drug Abuse ond Drug Dependancy as a Psychiatric Problem"
Sidney Cohen, M.D., Chevy Chase, Md.

2:40 Discussion

3:00 Intermission to Visit Exhibits

3:30 "Treotment Decision Research"
Myron G. Sandifer, Jr., M.D., Lexington

3:45 Discussion

3:50 "Emergency Screening and Referral — I.S.R. — The Unique Contribution of the Comprehensive Care Centers"
John H. Parks, M.D., Lexington

4:05 Discussion

4:10 "Problems in Community Mentol Health"
Edward C. Frank, M.D., Louisville

4:25 Discussion

Kentucky Chapter, American College of Radiology
Room 208, Convention Center

2:00 "The Role of Rodiotion Theropy in Carcinoma of the Larynx"
Ricardo R. Fuste, M.D., Memphis, Tenn.

Kentucky Urological Association
Room 203, Convention Center

2:00 "Corcinoma of the Prostrate"
Willet F. Whitmore, Jr., M.D., New York, N.Y.

3:00 Intermission to Visit Exhibits

3:30 Pyelogram Hour

4:20 Business Meeting

WEDNESDAY, SEPTEMBER 24
MORNING SESSION

General Session

Edwin P. Solomon, Jr., M.D., Louisville
Vice President, Presiding.

9:00 "Steroid Replocement Theropy"
Warren H. Pearse, M.D., Omaha, Neb.

9:20 "The Rotionol Bosis for Beto-Blockades for the Treotment of Arrhythmias"
Alon P. Winnie, M.D., Chicago, Ill.

9:40 "The Current Stotus of Drug Abuse"
Sidney Cohen, M.D., Chevy Chase, Md.

10:00 Intermission to Visit Exhibits

10:30 "Cardioc Transplonts"
Allen M. Lansing, M.D., Louisville

10:50 "Corneal Transplonts"
Roderick Macdonald, Jr., M.D., Louisville

11:10 "Recent Advances in Liver Transplantation"
Israel Penn, M.D., Denver, Colo.

11:30 Presentotion of Scientific Exhibit Award

WARREN H. PEARSE, M.D.
Omaha, Nebraska



Assistant dean, College of Medicine, University of Nebraska; staff, University of Nebraska Hospital. M.D., 1951, Northwestern University. Member, Association of Professors of Gynecology and Obstetrics, Fellow, American College of Obstetrics and Gynecology. OB-GYN Consultant, U.S. Fifth Army. Associate Examiner, American Board of Obstetrics and Gynecology.

SIDNEY COHEN, M.D.
Chevy Chase, Maryland

Chief, Center for Studies of Narcotic and Drug Abuse, National Institute of Mental Health, M.D., 1938, Germany. Editor, Journal of Psychopharmacology. Editorial Board, Psychosomatics. Member, Academy of Psychosomatic Medicine. Author of over 100 scientific articles and several books, including "LSD" and "The Drug Dilemma"



JOHN C. DUFFY, M.D.
Armonk, New York

Medical director, IBM Corporation. M.D., 1946, Stanford University. Fellow, American College of Preventive Medicine. Fellow, Industrial Medicine. Member, American Academy of Occupational Medicine, New York State Society of Industrial Medicine.



PRESIDENT'S LUNCHEON

Flag Room, Kentucky Hotel
11:50 a.m.

Henry B. Asman, M.D., Louisville, KMA President, Presiding

Invocation
The Most Rev. Thomas J. McDonough
Archbishop of Louisville

Recognition
Henry B. Asman, M.D.

Awards Presentation
Richard F. Grise, M.D., Bowling Green
Chairman, KMA Awards Committee

"The Future of Freedom"
M. Stanton Evans, Editor, *Indianapolis News*

WEDNESDAY, SEPTEMBER 24
AFTERNOON SESSION

General Session

L. C. Hess, M.D., Florence, Chairman, Board of Trustees, Presiding

2:15 **PANEL DISCUSSION: "Obesity"**
George W. Pedigo, M.D., Louisville, Moderator
John C. Duffy, M.D., Armonk, N.Y.
Earl E. Vastbinder, M.D., Lexington
John S. Llewellyn, M.D., Louisville

3:15 **Intermission to Visit Exhibits**

3:45 **CRACKERBARREL SESSION**
"Circulatory Collapse and Septic Shock"
Mohammed Atik, M.D., Louisville
"Obstructive Pulmonary Diseases"
William H. Anderson, M.D., Louisville
"Alcoholism and Drug Abuse"
Sidney Cohen, M.D., Chevy Chase, Md.
"Contraceptive Methods"
Warren H. Pearse, M.D., Omaha, Neb.
"Vascular Complications of Diabetes"
Marvin D. Siperstein, M.D., Ph.D., Dallas, Tex.
"Clinical Missed Diagnoses as Clarified by Catheterization"
Robert L. Grissom, M.D., Omaha, Neb.
"The Regulation and Treatment of Arrhythmias"
Alon P. Winnie, M.D., Chicago, Ill.
"Management of Cardiac Emergencies"
Karl Yoshonis, M.D., Lexington
"Management of Malignant Diseases"
John Yarbro, M.D., Lexington
"Sexual Problems in Medical Practice"
Cornelia Wilbur, M.D., Lexington
Robert Aug, M.D., Lexington
"Surgical Treatment of Parkinson's Disease"
H. Martin Blacker, M.D., Lexington
"High Risk Pregnancy"
J.W. Greene, Jr., M.D., Lexington
"High Risk Infants"
Billy F. Andrews, M.D., Louisville
"Organ Transplantation"
Israel Penn, M.D., Denver, Colo.
"Instant Radiographic Diagnosis"
Harold Rosenbaum, M.D., Lexington
"Computer Applications to Medicine"
John C. Duffy, M.D., Armonk, N.Y.

EARL E. VASTBINDER, M.D.

Lexington, Kentucky

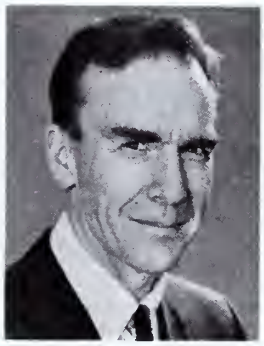


Assistant professor of pediatrics, University of Kentucky. Adolescent clinic staff. Assistant pediatrician, University Hospitol. M.D., 1961, M.Sc., 1967, Ohio State University. Member of Governor's Conference on Drug Abuse. Member, Ambulatory Pediatric Association, Society for Adolescent Medicine. Medical Coordinator, Children's Bureau of Fayette County. Director, Health Service Research Unit.

ROBERT L. GRISSOM, M.D.

Omaha, Nebraska

Professor and chairman of department of medicine, University of Nebraska. M.D., 1941, University of Illinois. Trustee, Nebraska Heart Association, Nebraska Society of Internal Medicine. Member, Association of University Cardiologists, Council on Clinical Cardiology. Regional secretary, National Board of Medical Examiners. Fellow, American College of Physicians.



JACK C. GEER, M.D.

Columbus, Ohio



Professor and chairman, department of pathology, Ohio State University. M.D., 1956, Louisiana State University. Member, American Association of Pathologists and Bacteriologists, American Society for the Advancement of Science, Council on Arteriosclerosis, American Heart Association, International Academy of Pathology, American Society of Clinical Pathologists.

"Cardiac Surgery, Indications and Results"
Allan Lansing, M.D., Louisville
"Consideration in the Management of Ocular Trauma"
Roderick Macdonald, Jr., M.D., Louisville
"Female Sterilization—Indications and Techniques"
Walter M. Wolfe, M.D., Louisville
"Problems in the Diagnosis and Management of Thyroid Diseases"
Beverly T. Towery, M.D., Louisville
"Management of Drug Poisoning"
Eugene H. Conner, M.D., Louisville

THURSDAY, SEPTEMBER 25 MORNING SESSION

General Session

George A. Selzlinger, M.D., Louisville, Vice Chairman, Board of Trustees, Presiding

9:00 PANEL DISCUSSION: "New Concepts in the Management of the Patient with Atherosclerosis"
Beverly T. Towery, M.D., Louisville, Moderator
Robert L. Grissom, M.D., Omaha, Neb.
Jack C. Geer, M.D., Columbus, Ohio
Marvin D. Siperstein, M.D., Ph.D., Dallas, Tex.
C. Thomas Flotte, M.D., Baltimore, Md.

10:15 Intermission to Visit Exhibits

10:45 PANEL DISCUSSION: "School Health, Physical Education and Medical Aspects of Sports"
O.B. Murphy, M.D., Lexington, Moderator
Marvin Barnett, D.M.D., Louisville
Fred L. Allman, Jr., M.D., Atlanta, Ga.
Allan J. Ryan, M.D., Madison, Wisc.

Specialty Group Session
Kentucky EEN&T Society
Room 205, Convention Center

9:00 "Diabetic Retinopathy and Its Treatment with Photocoagulation"
Patrick R. O'Connor, M.D., Louisville

9:30 "Laryngeal Lesions in Children"
Fielding Daniel, M.D., Louisville

10:00 Intermission to Visit Exhibits

10:30 "Reconstructive Principles and Problems for the Otolaryngologist"
Charles W. Gross, M.D., Memphis, Tenn.

11:30 Business Meeting

THURSDAY, SEPTEMBER 25 AFTERNOON SESSION

Eight Specialty Group Meetings

(Eight specialty groups will meet at 2 p.m. with outstanding speakers appearing on their programs. All KMA members are invited to these meetings. No general session will be held.)

Kentucky EEN&T Society
Room 205, Convention Center,

2:00 "Modern Advances and Complications of Cataract Surgery"
R.M. Fasanella, M.D., New Haven, Conn.

3:00 Intermission to Visit Exhibits

3:30 "Surgical Problems"
R.M. Fasanella, M.D., New Haven, Conn.

MARVIN D. SIPERSTEIN, M.D.
Dallas, Texas



Professor of internal medicine, University of Texas Southwestern Medical School. Senior attending staff, internal medicine, Parkland Memorial Hospital. M.D., 1948, University of Minnesota. Ph. D., 1953, University of California. Consultant, United States Public Health Service. Modern Medicine Distinguished Achievement Award, 1969. Editorial Board, Journal of Atherosclerosis Research, Diabetes Journal, Advances in Internal Medicine. Past president, Dallas Diabetes Association.

FRED L. ALLMAN, JR., M.D.
Atlanta, Georgia

Staff member, Atlanta Orthopaedic Clinic. M.D., 1955, Medical College of Georgia. Chairman, School Child Health Committee, Medical Association of Georgia. Member, Research Task Force, President's Council on Physical Fitness, American Academy of Orthopaedic Surgeons. Author of numerous publications and three sound movies in the field of sports medicine and physical fitness.



C. THOMAS FLOTTE, M.D.
Baltimore, Maryland



Director of surgery education, Maryland General Hospital. M.D., 1946, Jefferson Medical College. Editor, Maryland State Medical Journal. Medical Board, American Red Cross. Member, American College of Surgeons, American Association Advancement of Science, Association of American Medical Colleges, American Geriatrics. Served on Council on Arteriosclerosis and Cardiovascular Disease, American Heart Association.

Kentucky Chapter, American Academy of General Practice

Assembly Hall, Convention Center

2:00 "Stress Tests as an Aid to Diagnosis of Central and Peripheral Arteriosclerosis"
Robert L. Grissom, M.D., Omaha, Neb.

3:00 Intermission to Visit Exhibits

Kentucky Industrial Medical Association

Room 203, Convention Center

2:00 "Health Screening on an International Basis"
Michael J. McNamara, M.D., Lexington

3:00 Intermission to Visit Exhibits

3:30 "Pulmonary Screening in Industry"
John C. Duffy, M.D., Armonk, N.Y.

Kentucky Orthopaedic Society

Room 101, Convention Center

(To Be Announced)

Kentucky Society of Pathologists

Room 208, Convention Center

2:00 "Perforating Dermatoses"
Daniel Richfield, M.D., Covington

2:30 "Pathologic Changes in a Patient Who Received a Heart Transplant"
James McAdams, M.D., Cincinnati, Ohio

3:00 Intermission to Visit Exhibits

3:30 "Laboratory Evaluation of Hypertension"
John Koepke, M.D., Lexington

4:00 "Aterial Wall Metabolism and Atherosclerosis"
Jack C. Geer, M.D., Columbus, Ohio

Kentucky Chapter, American College of Physicians

Room 204, Convention Center

2:00 "Meningitis"
Paul C. Grider, M.D., Louisville

2:30 "Alkaline Phosphatase"
Charles C. Smith, M.D., Louisville

3:00 Intermission to Visit Exhibits

3:30 "The Nature of Vascular Diseases in Diabetes Mellitus"
Marvin D. Siperstein, M.D., Ph.D., Dallas, Tex.

4:00 "Management of Hyperlipidemias"
Maurice Best, Jr., M.D., F.A.C.P., Louisville
Charles H. Duncan, M.D., Louisville

Kentucky Association of Public Health Physicians

Room 207, Convention Center

2:00 "Health Problems of Adolescence"
Earl E. Vastbinder, M.D., Lexington

2:30 Discussion

3:00 Intermission to Visit Exhibits

3:30 Business Meeting

RODERICK MACDONALD, JR., M.D.

Louisville, Kentucky



Associate Dean for clinical affairs, University of Louisville School of Medicine. M.D., 1950, Medical College of South Carolina. Medical director, Kentucky Lions Eye Foundation. Member, Governor's Commission for the Kentucky Blind School, New Orleans Academy of Ophthalmology, Pan American Association of Ophthalmology, Eye, Ear, Nose, and Throat Society.

Kentucky Chapter, American College of Surgeons

Room 104, Convention Center

2:00 "Protean Manifestations of Amoebic Colitis"
E. Truman Mays, M.D., Louisville

2:15 "Mediastinoscopy—Techniques and Results"
J. Kent Trinkle, M.D., Lexington

2:30 "Experience with Resection of Abdominal Aortic Aneurysms"
C. Thomas Flotte, M.D., Baltimore, Md.

3:00 Intermission to Visit Exhibits

3:30 "Childhood Intussusception"
Bernard J. Schoo, M.D., Louisville

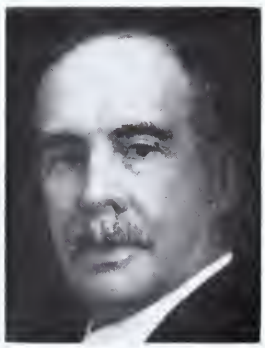
3:45 "A New Method in the Treatment of Snake Bites"
Joseph L. Milburn, M.D., Madisonville

4:00 "Chronic Osteomyelitis of the Tibia"
Francis X. Sommer, M.D., Barbourville

4:15 "Non-Beta Islet Cells Tumors of Pancreas"
Fred T. Moore, M.D., Louisville

Lewis McMurtry, 1889 President To Be Honored At KMA Meeting

The official title of the 1969 Annual Meeting of the KMA will be the Lewis S. McMurtry Memorial Meeting in honor of the Association's 1889 President.



The Association established the practice in 1935 of honoring a past president or other outstanding physician at each Annual Meeting. Following this tradition, Doctor McMurtry will be honored this year.

A descriptive biography of Doctor McMurtry, a Louisville physician, will be contained in the program booklet for the Annual Meeting. Eugene H. Conner, M.D., Louisville, KMA historian, will write the biography available in the booklet at the meeting, September 23, 24 and 25.

Speakers, Crackerbarrel Session To Highlight Scientific Program

Sixteen prominent physicians will be guest speakers during the four general scientific sessions and will also participate in the meetings of the 16 specialty groups at the KMA Annual Meeting September 23-25.

The guest physicians, all well-known in their respective fields of medicine, will come to Kentucky from all parts of the country.

The scientific program of this year's Annual Meeting will feature discussions of "Cancer," "Drugs," "Transplants," and "Atherosclerosis." Following a panel discussion on "Obesity" in the Wednesday afternoon scientific session, 20 timely medical topics will be discussed in a new Crackerbarrel Session. Other talks are scheduled to complement the speakers' presentations and to enrich the entire program.

Other highlights of the Annual Meeting will include the President's Luncheon, meetings of the KMA House of Delegates, an Orientation program for new members, the Annual Convention of the Woman's Auxiliary to KMA and the annual KEMPAC seminar. Seventy-five technical exhibits, displayed during the three-day meeting, will give KMA members an excellent opportunity to view a variety of the latest medical products and services.

U Of L Plans 9 Alumni Reunions During KMA Annual Meeting

Alumni reunions are planned for nine five-year classes of the University of Louisville School of Medicine during the KMA Annual Meeting in September, according to Les Shively of the Alumni office.

A tour of the Medical School and individual functions are being planned by the chairman of each group. Following is a list of the chairmen selected this year.

1924—David M. Cox, M.D., 102 Breckinridge Lane, Louisville, 897-2531

1929—Margaret A. Limper, M.D., 1405 E. Burnett St., Louisville, 635-5291

1934—H. David Chipps, M.D., 1636 Nicholasville Road, Lexington, 278-2327

1939—Chairman to be selected

1944—Gordon L. Smiley, M.D., 1147 Medical Arts Bldg., Louisville, 454-5861

1949—William B. Clark, Jr., M.D., 435 Spring St., Jeffersonville, Ind., 282-2883

1954—Milton F. Miller, M.D., 662 Medical Towers South, Louisville, 583-0453

1959—Neville W. Caudill, M.D., 504 Medical Towers, Louisville, 899-3441

1964—Ronald G. Chism, M.D., 5135 Dixie Highway, Louisville, 447-3242

Editor To Talk, Awards Given At KMA President's Luncheon

The President's Luncheon for physicians and their wives on September 24 will feature a talk by M. Stanton Evans, editor of the *Indianapolis News* and the presentation of KMA's three top awards.

Mr. Evans will talk on "The Future of Freedom" at the luncheon held in the Flag Room of the Kentucky Hotel. Preceding his address the Distinguished Service Medal, the Outstanding General Practitioner Award and the R. Haynes Barr Award will be presented.

A winner of four Freedoms Foundation George Washington medals and a well-known author, Mr. Evans was named editor of the *News* in 1960 after serving as chief editorial writer. He is also an associate editor and regular columnist for *National Review*.

The recipient of the R. Haynes Barr Award is selected by the Awards Committee, chaired by Richard F. Grise, M.D., Bowling Green. The award is given in recognition for outstanding contributions to medicine by a layman. The Committee will present the nominations for the other two awards, which are given to physicians, to the House at its first session. Other nominations may be made from the floor. Nominations may be mailed now to KMA Headquarters Office.

The Awards Committee members are Doctor Grise, William A. Blodgett, M.D., Louisville; Frank L. Duncan, M.D., Monticello; C. Wayne Franz, M.D., Ashland; and Joseph Keith, Jr., M.D., Lexington.

KIMA Luncheon To Honor Dr. Duffy

The Kentucky Industrial Medical Association will hold a luncheon meeting during the KMA Annual Meeting Thursday, September 25 in Ship Room, Kentucky Hotel. The luncheon session is to be in honor of John C. Duffy, M.D., medical director of IBM Corporation in New York. Doctor Duffy will be speaker for the luncheon which will adjourn in time for the KIMA specialty session at 2 p.m.

Take This Issue Home To Your Wife

This issue of The Journal features the program of the Woman's Auxiliary Annual Convention as well as other activities planned during the KMA Annual Meeting which will be of interest to your wife. KMA President Henry B. Asman, M.D., urges you to take this issue home for her to read.

Scientific Committee Chooses Twelve Exhibits for Meeting

The KMA Annual Meeting will feature 12 outstanding scientific exhibits this year, according to T. R. Marshall, M.D., Louisville, chairman of the Scientific Exhibits Committee.

Covering a variety of medical topics, the exhibits will depict recent developments in research and techniques. Each participating exhibitor will be awarded a certificate from KMA and the winning exhibitor will receive a plaque.

The scientific exhibits, conveniently arranged for easy access, will be located between the Technical Exhibit Hall and the Scientific Assembly Hall in Convention Center. A complete list of the scientific exhibits on display during the meeting follows.

Chemoprophylaxis of Tuberculosis
Joseph H. Humpert, M.D.

Hemophilia
Giovanni Raccuglia, M.D.
William Carney, M.D.

Diagnosis and Treatment of Rheumatoid Arthritis
William R. Murray, M.D.

Diagnose Gout and Treat It
Irvin F. Hermann, M.D.
Kenneth M. Kron, M.D.

Infusion Pyelography
T. R. Marshall, M.D.

Gastric-Tube Substitution for the Resected Esophagus
William C. Gardner, M.D.
Merle M. Mahr, M.D.

Complications of Hair Transplantation
D. B. Stough, III, M.D.

Educational Television Program
KMA Educational Television Committee
William P. VonderHaar, M.D., Chairman

Rehabilitation Center Services
Robert P. Smith, M.D.
Kathryn E. Abrams

Lung Cancer Screening Booth
Duane Tweeddale, M.D.

Library Sciences to Kentucky Hospitals OVRMP and KOMRML
Joan Titley

Professional Education Service
Kentucky State Department of Health

MAKE YOUR RESERVATIONS NOW

Hotel reservations for the KMA Annual Meeting September 23-25 should be made now in order to be sure of rooms. Hotels and motels in downtown Louisville have excellent accommodations and are available within easy access of Convention Center.

Pre-Register NOW for the 1969 Annual Meeting

You can save yourself time and avoid standing in a long line by completing the form below and sending it to the KMA Headquarters office as soon as possible.

Your badge will be ready at the window marked "Pre-Registration" on your arrival at the meeting.

It was felt by the Executive Committee that pre-registration, used for the first time at the KMA Annual Meeting, would be a benefit to those attending. Rather than filling out forms, more time could be spent in attending meetings or visiting exhibits.

We urge you to take advantage of this opportunity and send the form below today.

Delegates to KMA and members of the Board of Trustees do not need to pre-register as this is automatically done for them.

PRE-REGISTRATION FORM

1969 ANNUAL MEETING
CONVENTION CENTER
LOUISVILLE, KENTUCKY

KENTUCKY MEDICAL ASSOCIATION
SEPTEMBER 23-25, 1969

NAME _____ FIELD OF PRACTICE _____
(Please Print)

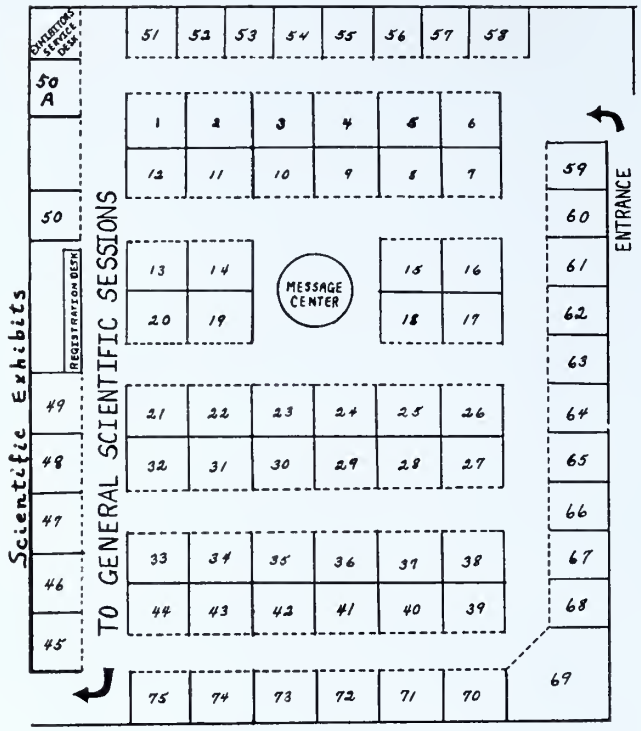
ADDRESS _____
(Number and Street) (City) (County) (State)

I am:

☐ KMA Member
☐ Non-member Physician
☐ Intern or Resident
☐ Medical Student

Return form to KMA Headquarters, 3532 Janet Avenue, Louisville, Ky. 40205

Seventy-five Technical Exhibits To Feature Latest Medical Products and Services



Floor Plan of Technical Exhibits

The 1969 KMA Annual Meeting will feature seventy-five technical exhibits in the hall at Convention Center. As you enter the hall, some of the latest developments in medical techniques and information will be displayed for your convenience and enjoyment. Exhibitors will be available to discuss their products with you and relate their latest discoveries and innovations. They can also show you the most up-to-date advances in their services.

The exhibits, prepared carefully and skillfully to appeal to you, the physician, have also been prepared to appeal to your special interests as a practitioner. A vast amount of knowledge and information can be secured conveniently and effortlessly in a short period of time.

Intermissions of 30 minutes have been scheduled during each general and specialty group session so that every KMA member may take advantage of this excellent opportunity provided by the exhibits.

TECHNICAL EXHIBITORS

Abbott Laboratories (20)
Arnar-Stone Laboratories, Inc. (57)
Audio Digest Foundation (34)
Automated Management Systems (67 and 68)
Ayerst Laboratories (45)
Blue Cross & Blue Shield, Kentucky (40)
Borden Company, The (28)
Bristol Laboratories (22)
Burroughs Wellcome & Co. (U.S.A.), Inc. (39)
Burton, Parsons & Company, Inc. (75)
Carnation Company (54)
CIBA Pharmaceutical Co. (18)
Coca-Cola USA (69)
Copy Van of Louisville, Inc. (42)
Crocker-Fels Co., Inc. (46)
Dairy Council, Inc. (62)
Dictaphone Corporation (27)
Donnellon McCarthy, Inc. (30)
Doyle Pharmaceutical Company (65)
Eaton Laboratories (50)
Emko Company (43)
Encyclopaedia Britannica, Inc. (64)
Field Enterprises Educational Corp. (36)
Flint Laboratories (25)
Gerber Products Company (24)
Guild of Prescription Opticians of Kentucky (9)
John Hancock Mutual Life Insurance Co. (71)
Kay Surgical, Inc. (59)
Lederle Laboratories (14)
Lee, A.P., Agency (52)
Lilly, Eli & Company (12)
Lippincott, J.B., Company (5)
Lorillard Corporation (38)
Louisville Surgical Supply (41)
Louisville Pepsi & Seven-Up Bottlers Association (53)
Malkin Instrument Co., Inc. (17)
Mead Johnson Laboratories (8)
Medical Electronics Company (66)
Medical Protective Co., The (63)
Merck Sharp & Dohme (6)
Merrell, William S., The, Co. (23)
Metropolitan Life Ins. Co. (Medicare) (29)
Meyer Laboratories, Inc. (4)
Monarch Auto Company (Concourse)
Mutual Benefit Life Ins. Co. (47)
Ortho Pharmaceutical Corp. (1)
Parke, Davis & Co. (49)
Pfizer Laboratories (44)
Poythress, Wm. P. & Co., Inc. (55)
Programmed Learning, Inc. (31)
Ransdell Surgical, Inc. (37)
Reynolds, R. J., Tobacco Co. (51)
Robins, A.H., Company (13)
Roerig, J.B., Division, Chas. Pfizer & Co., Inc. (60)
Rorer, William H., Inc. (32)
Ross Laboratories (58)
Sandoz Pharmaceuticals (10)
Saunders, W.B., Company (72)
Schering Laboratories (48)
Screen, Inc. (35)
Scroggins, Clayton L., Associates (3)
Searle, G.D. & Company (33)
Smith Kline & French Laboratories (21)
Smith, Miller & Patch, Inc. (16)
Squibb, E.R., & Sons (7)
Stuart Division, Atlas Chemical (2)
Tele-Business Products Company (74)
United Medical Laboratories, Inc. (73)
Warner-Chilcott Laboratories (19)
Warren-Tedd Pharmaceuticals, Inc. (61)
Winthrop Laboratories (26)
Wocher, The Max & Son Company (15)
Wyeth Laboratories (11)
Zimmer Manufacturing Company (56)

PROGRAM
FORTY-SEVENTH ANNUAL CONVENTION
Of The
WOMAN'S AUXILIARY
To The
KENTUCKY MEDICAL ASSOCIATION

SEPTEMBER 22-23-24

1969

KENTUCKY HOTEL **LOUISVILLE, KENTUCKY**

General Information

CONVENTION REGISTRATION

Lobby

Monday	12 Noon-5:00 PM
Tuesday	7:30 AM-5:00 PM
Wednesday	9:00 AM-11:00 AM

MONDAY, SEPTEMBER 22

Orientation Program for New Members
Mirror Room, 2-4 PM

Chairman Mrs. Kenneth Hodge

TUESDAY, SEPTEMBER 23

Pre-Convention Board Meeting Breakfast
Parlor B, 8:30 AM

All general officers, chairmen of standing and special committees, three immediate past presidents, councilors, co-ordinator for members-at-large and county presidents.

COFFEE
Mezzanine, 9:00 AM

FORMAL OPENING OF THE 47th ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE KENTUCKY MEDICAL ASSOCIATION
MIRROR ROOM, 10:00 AM

Mrs. William H. McBeath, President, presiding

Invocation Mrs. Earl Roles, Louisville, Chaplain

Pledge of Allegiance to the Flag
Mrs. David Stevens, Lexington

WA-KMA Objectives Mrs. Joseph Parker, Lexington

Welcome to the City of Louisville Mrs. Kenneth Schmied, Wife of Louisville's Mayor

Welcome of the Host Auxiliary. Mrs. George Schafer, President, Jefferson County Auxiliary

Presentation of Distinguished Guests
Mrs. William McBeath

Adoption of Convention Rules
Mrs. J. Murray Kinsman, Louisville, Parliamentarian

Announcements Mrs. Robert Tate, Louisville, Convention Chairman

Roll Call of Delegates

Minutes of 46th Annual Meeting
Mrs. C. E. Hornaday, Owensboro, Recording Secretary

Report of the 1969 National Convention
Mrs. C. Kenneth Peters, Louisville

Greetings Mrs. James Duncan, Lexington, WA-SAMA, University of Kentucky

Greetings Mrs. Jay Garsman, Louisville, WA-SAMA, University of Louisville

Greetings Mrs. Virgil Ray Forester, President, Woman's Auxiliary to the Southern Medical Association

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. J. Jack Martin, Tompkinsville

President's Report Mrs. William H. McBeath

Report of Officers

President-Elect Mrs. Hoyt Gardner, Louisville

Vice-Presidents ...Mrs. F. H. Hodges, Pikeville
Mrs. James A. Harris, Paducah
Mrs. O. J. Stein, Somerset
Mrs. David Stevens, Lexington

Treasurer Mrs. Bernard Schoo, Louisville

Corresponding Secretary Mrs. John Berry, Lexington

Report of Councilors

Report of State Chairman

Unfinished Business

New Business

Amendments Mrs. J. Murray Kinsman, Parliamentarian

Report of the Nominating Committee
Mrs. Charles Kissinger, Henderson

Presentation of the 1969-70 Budget
Mrs. William C. Durham, Louisville

Election of the 1969-70 Nominating Committee

Report of Registration Mrs. Roger Queens, Louisville

In Memoriam Service Mrs. Earl Roles, Chaplain, Louisville

LUNCHEON
TERRACE ROOM, 12:15 PM

Honoring

Past Presidents, Members-at-Large, Distinguished Guests

Invocation Mrs. James Rackley, Lexington

Skit Hopkins County Medical Auxiliary
Mrs. W. A. Kirchner, Chairman

Community Service Award Mrs. Graydon Long, Lexington, Community Service Chairman

Guest Speaker
Mrs. R. C. L. Robertson, Houston, Texas
National President-Elect

BON VOYAGE PROGRAM
Stewart's Department Store Auditorium, 3:00 PM

KMA and WA-KMA COCKTAIL PARTY
MIRROR ROOM, 5:30-7:00 PM

Honoring

KMA President-Elect Walter Cawood, M.D.

WA-KMA President-Elect Mrs. Hoyt Gardner

WEDNESDAY, SEPTEMBER 24

COFFEE AND ROLLS
Mezzanine, 8:30 AM

HOBBY SHOW, EXHIBITS AND GIFT BOUTIQUE
on display

MIRROR ROOM, 9:00 AM

Invocation Mrs. Meredith Evans, Middlesboro

Roll Call

Reading of Minutes Mrs. C. E. Hornaday

Greetings Mrs. Louie Nunn, Kentucky's First Lady

Announcements

M.D. Wife's Award Mrs. C. Fred Blankenship, Chairman

County Presidents' Reports

Election of Officers

Installation of Officers Mrs. R. C. L. Robertson, National President-Elect

Presentation of Gavel and Pin
Mrs. William H. McBeath

Inaugural Address Mrs. Hoyt Gardner

Presentation of Past President's Pin ..Mrs. Earl Roles

Greetings Henry B. Asman, M.D., Louisville, KMA President

Courtesy Resolution Mrs. Harold Graves, Louisville

PRESIDENT'S LUNCHEON WITH DOCTORS
Flag Room, 12:00 Noon

POST-CONVENTION BOARD MEETING
Mirror Room, 2:00-4:00 PM

1969 STATE CONVENTION COMMITTEES

General Chairman Mrs. Robert C. Tate, Louisville

Co-Chairman Mrs. John J. Ryan, Louisville

Registration Mrs. Rogers L. Queen, Louisville

Finance Mrs. Bernard J. Schoo, Louisville

Hospitality ...Mrs. William C. Edwards, Louisville

Tuesday Pre-Convention Breakfast and Tuesday Luncheon Mrs. Harold Q. Davis, Louisville

Co-Chairman Mrs. R. Parnell Rollings, Louisville

Publicity, Press Mrs. Charles F. Blankenship, Louisville

Publicity, Radio-TV Mrs. Daniel W. Burke, Louisville

Hobby Show Mrs. Fielding W. Daniel, Louisville

Exhibits Mrs. Walter E. Badenhausen, Louisville

Tickets Mrs. William F. Hawn, Louisville

Stewart's Program Mrs. John W. Miller, Louisville

M.D. Wife's Award

Chairman Mrs. Charles F. Blankenship

Co-Chairman Mrs. Clinton C. Cook Jr., Louisville

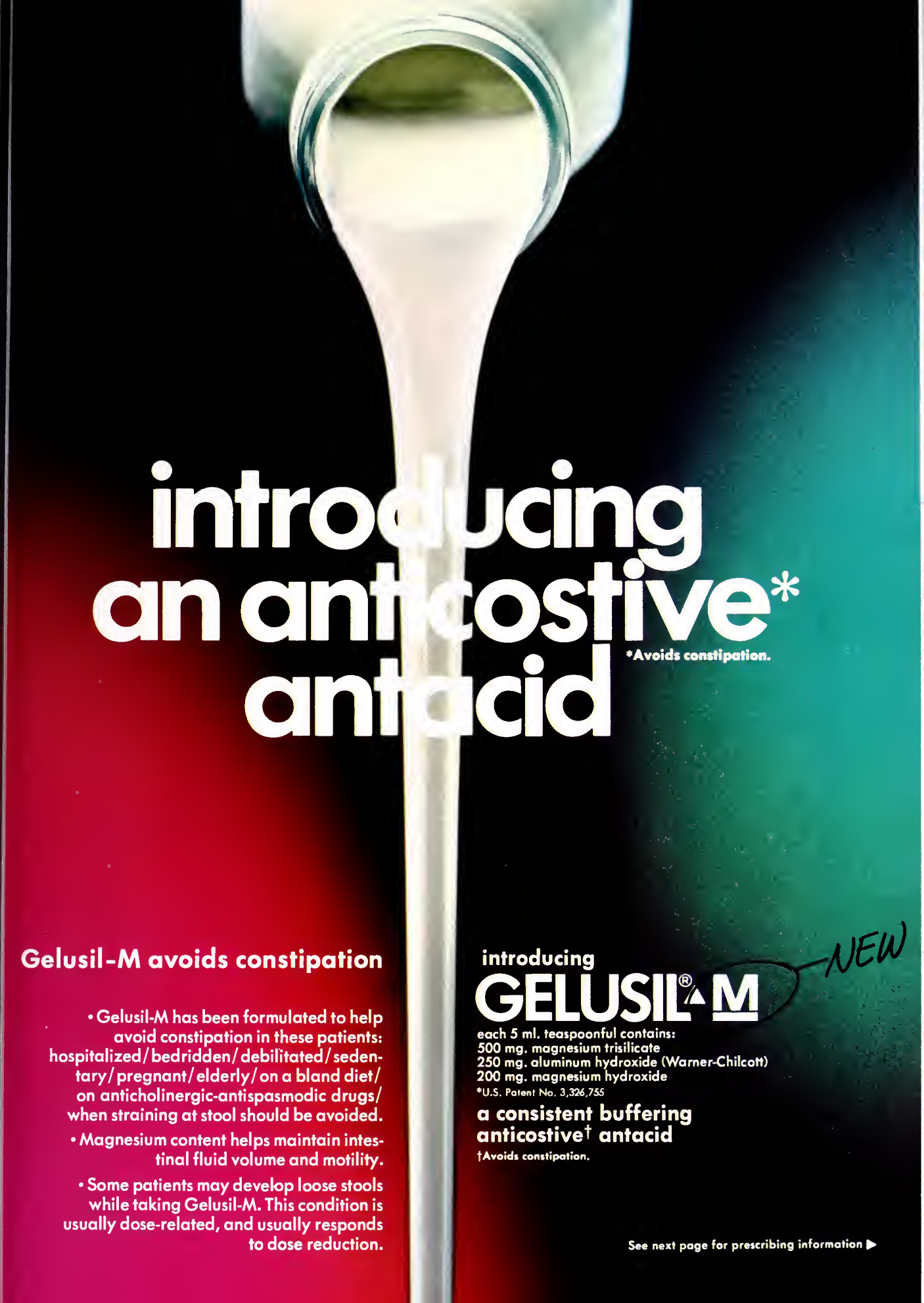
Decorations Mrs. Robert R. O'Conner, Louisville

Official Hostesses
Mrs. Kenneth W. Hodge, Chairman
Mrs. Walter Badenhausen, Jr.
Mrs. Fielding Daniel
Mrs. Raymond Jones
Mrs. J. Murray Kinsman
Mrs. James T. Linville

Tellers Mrs. Charles W. Justice, Ludlow
Mrs. Marvin Keeton, Ashland
Mrs. Harold Priddle, Paducah
Mrs. David Brown, Lexington

Timekeepers Mrs. Bernard Asman, Louisville
Mrs. Eli George, Lebanon
Mrs. Lee Hess, Florence
Mrs. Sam Lykins, Lexington

Courtesy Resolutions Mrs. Harold B. Graves, Louisville



introducing an anticostive* antacid

*Avoids constipation.

Gelusil-M avoids constipation

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing

GELUSIL® M

NEW

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide
*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patien



Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquic

Pleasant mint flavor...ideal for hospi tal or home. Available in 12 fl. oz. an 6 fl. oz. bottles and a special hospitc pack. An antacid which contains adsor bent and demulcent agents in each ml. teaspoonful: 0.25 Gm. aluminur hydroxide (Warner-Chilcott), 0.5 Gm magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)- or more—between meals and at bed time, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey

GM-IN-92-4C

ORGANIZATION SECTION

Health Consultant Appointment Goes to Dr. Gradie Rowntree

Gradie R. Rowntree, M.D., has been appointed Consultant to the Kentucky Commissioner of Health in Occupational Health. In this capacity he will work with medical staffs in industries and explore ways to extend occupational health programs to industries having no medical program.



Doctor Rowntree

A past medical director of Fawcett-Haynes Printing Corporation in Louisville, Doctor Rowntree is a professor of occupational medicine in the University of Louisville School of Medicine.

Doctor Rowntree, a past president of the Kentucky Industrial Medical Association, received the Physicians Award for outstanding contribution to the employment of the nation's handicapped from former President Dwight Eisenhower.

Interim Dean Names 2 at U.L.

The interim dean of the University of Louisville School of Medicine, Douglas Haynes, M.D., has chosen Roderick Macdonald, M.D. and Richard H. Swigart, M.D. to assist him in his new office.

Doctor Macdonald will be associate dean for clinical affairs and will be in charge of programs for interns and residents at hospitals affiliated with the University. Doctor Swigart will serve as associate dean for student affairs and curriculum.

Physical Fitness Award Given To Dr. Kelley of Somerset

Stephen B. Kelley, M.D., Somerset, received one of 12 national Physical Fitness Leadership Awards from the President's Council on Physical Fitness and Sports at Washington, D.C. recently. The competition is sponsored annually by the Council, Metropolitan Life Insurance Company and the U.S. Jaycees.

Cited for his work in initiating a community fitness program for men between the ages of 21 and 87, Doctor Kelley was chosen from more than 1,250 applicants. He had previously won the Pulaski County and Kentucky awards.

In addition to his work in this program, Doctor Kelley is active as a scout master and in this capacity encourages boys to compete for the personal fitness merit badge.

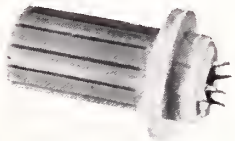
MESSAGE CENTER

584-2201

You may be reached through this number at the Convention Center during the KMA Annual Meeting September 23-25.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

Opportunities Available to General Practitioners Through KMA Physicians Placement Service

The Physicians Placement Service of the Kentucky Medical Association, in an effort to obtain a better distribution of physicians in our state, is listing below the many practice opportunities available for general practitioners, and would encourage any physician desiring to relocate his practice to contact KMA's Physicians Placement Service for detailed information on any opportunity listed below.

We do our best to provide a two-way flow of information between interested parties without actually recommending or becoming involved in any negotiations.

This list includes three breakdowns: one indicating communities where local citizens are hoping to encourage a doctor to establish a practice in their area; general practitioners in the rural area in need of replacements; and physicians desiring association. This last section includes opportunities for partnership, or in group practices, quite often with no investment necessary and offering a specified minimum salary in the beginning.

If you are interested in any particular area, please let us know, and we will be happy to provide additional details.

COMMUNITIES SEEKING PHYSICIANS

General Practitioners

County	City	County	City
Butler	Morgantown	Logan	Adairville
Clinton	Albany	Logan	Auburn
Grayson	Leitchfield	McCracken	Reidland
Greenup	Raceland	Marshall	Hardin
Greenup	Russell	Nelson	Bloomfield
Harlan	Evarts	Ohio	Fordsville
Hart	Horse Cave	Owen	Owenton
Knox	Barbourville	Shelby	Shelbyville
		Webster	Sebree

PHYSICIANS DESIRING REPLACEMENTS

General Practitioners

County	City	County	City
Bourbon	Paris	Madison	Berea
Carter	Grayson	Muhlenberg	Central City
Clark	Winchester	Nelson	Bloomfield
Fayette	Lexington	Nicholas	Carlisle
Garrard	Lancaster	Shelby	Shelbyville
Graves	Mayfield	Todd	Elkton
Lincoln	Stanford	Wolfe	Campton
Mason	Maysville		

PHYSICIANS DESIRING ASSOCIATES

General Practitioners

County	City	County	City
Adair	Columbia	Henderson	Henderson
Anderson	Lawrenceburg	Hopkins	Madisonville
Barren	Glasgow	Laurel	London
Bell	Middlesboro	Letcher	Whitesburg
Bourbon	Paris	Livingston	Salem
Caldwell	Princeton	McLean	Calhoun
Calloway	Murray	Madison	Richmond
Christian	Hopkinsville	Muhlenberg	Greenville
Daviess	Owensboro	Ohio	Beaver Dam
Edmonson	Brownsville	Oldham	LaGrange
Floyd	Martin	Perry	Hazard
Floyd	McDowell	Pulaski	Somerset
Graves	Mayfield	Russell	Jamestown
Greenup	Russell	Scott	Georgetown
Greenup	South Shore	Simpson	Franklin
Hardin	Elizabethtown	Webster	Providence
Harlan	Harlan	Wolfe	Campton



Kentuckians attending the AMA/AMPAC public affairs seminar May 16-18 in Washington, D.C., pose with Representative Gerald Ford, Michigan and several AMA officials. The delegation are (left to right, bottom row): Harry Hinton, manager, AMA Washington office; Gilbert Armstrong, KMA director of field services; Hoyt Gardner, M.D., national affairs chairman for KMA Committee on Legislative Activities; Jerry Mahoney, KMA assistant director of field services; Joe Miller, AMA director, public affairs division; Rep. Ford, Fred Rainey, M.D., state affairs chairman for KMA Committee on Legislative Activities; Mrs. Meredith Evans; Mrs. Hoyt Gardner; Meredith Evans, M.D., KEMPAC director; R. Burke Casper, M.D., KEMPAC director; (top row) John P. Stewart, M.D., KEMPAC director; John Quertermous, M.D., chairman of the KEMPAC Board; Walter Cawood, M.D., KMA president-elect; Jim Imboden, AMA field representative.

KSAMA Founds Danville Chapter

A new chapter of the Kentucky State Association of Medical Assistants was organized on June 22 in Danville, according to James R. Pleasant, Jr., public relations chairman for KSAMA

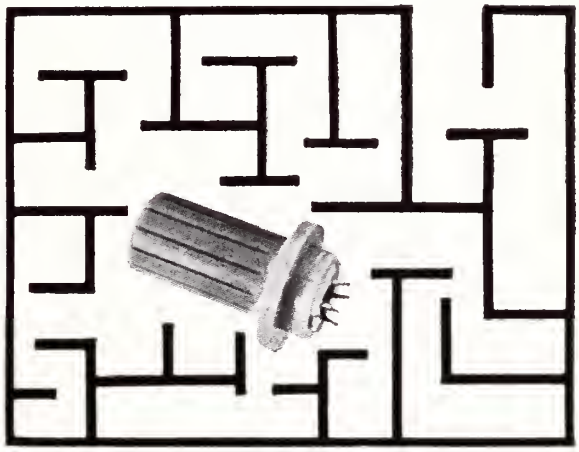
Officers for the new chapter, called "12th District Medical Assistants Association," are Sarah Miller, president; Jackie Dietrick, president-elect; Lou McCulley, vice-president; Donna Arnold, secretary; Mildred Simms, treasurer; and Kay Wesley, director.

Cancer Chemotherapy—Yarbo

(Continued from page 560)

Summary

Although chemotherapy offers a cure for metastatic cancer in only a few cases today, a substantial number of neoplasms are responsive and may be controlled for a variable period of time. Useful prolongation of life may be accomplished in many patients. The drugs used are quite toxic, however, and considerable harm may be done to patients by indiscriminate use. Therefore, it is essential to determine *in each patient* whether there is a response of the tumor to therapy and to continue therapy *only* if an objective response of the tumor is observed.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665.....President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660....Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123.....Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661.....Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211.....Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282.....Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552..Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340.....1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255.....1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362..1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231.....1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406.....1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751.....1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155....1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698.....1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357.....1969

Buyers Guide

AUGUST BUYERS GUIDE FOR JOURNAL OF KMA 1969

Bristol Laboratories 577
Burroughs Wellcome 592
Business & Professional Adjustment Service, Inc. S76

Geigy Pharmaceuticals S84-S86
General Leasing Corporation 547

Highland Hospital S76
Hynson, Westcott & Dunning 541

Kentucky Hotel 554-555

Lederle Laboratories S43, SS1, SS2, 559, 581, 619, 621
Lilly, Eli & Company S64

Medical Protective 581
Merrell, Wm. S., Company 623

National Drug Company S40, S49-S50

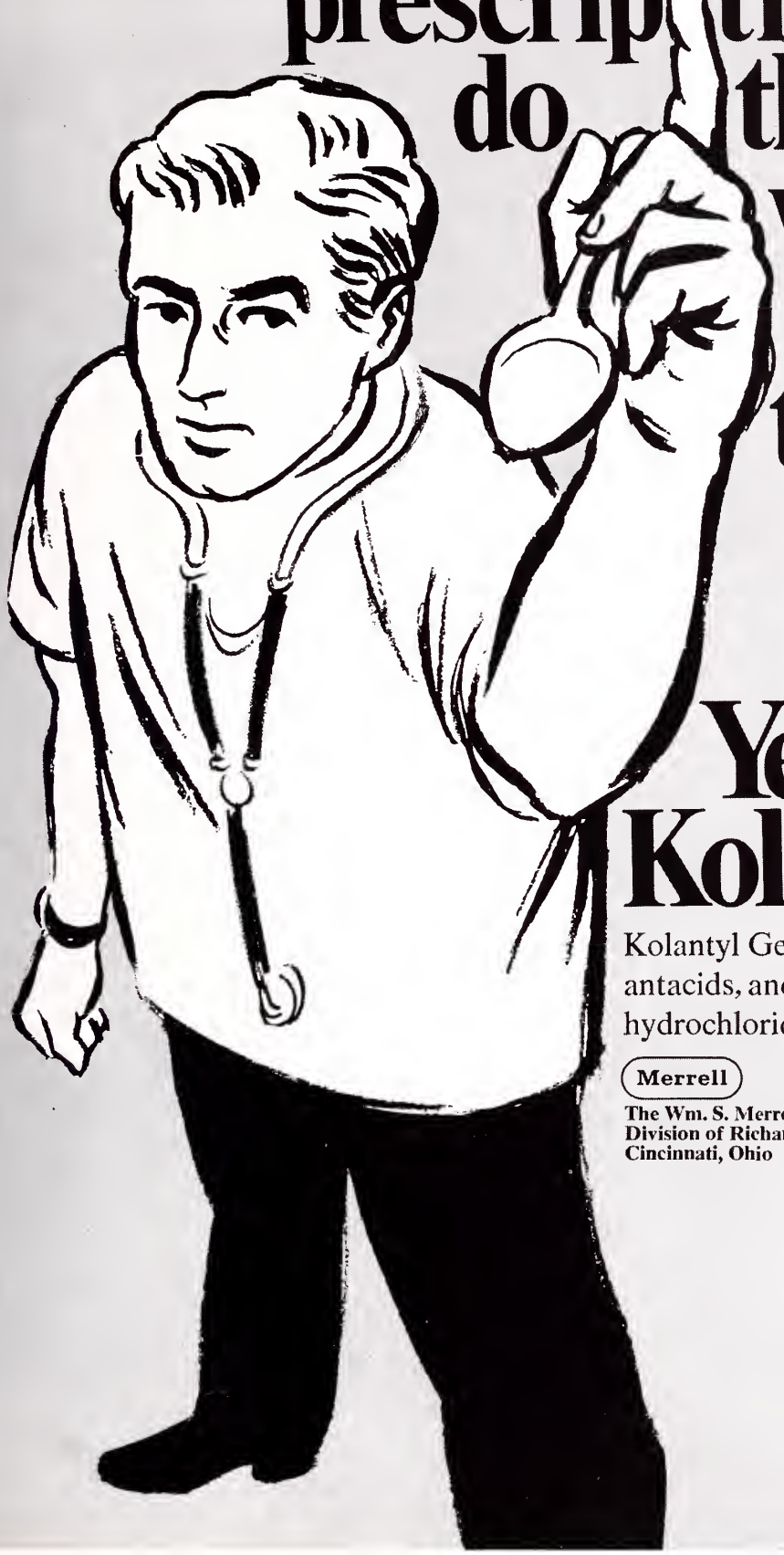
Parke, Davis Company S80
Pitman-Moore Company S60-S61

Riker Laboratories S46-S47
Roche Laboratories S88-S91, 624
Rorer, Wm. H. Company S4S

Searle, G. D. & Company S78-S79
Southern Optical Company SS1
Stuart Company SS3

Warner Chilcott Laboratories 617-618
Wyeth Laboratories SS6-SS7

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

9-1243

(0715)



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

VOLUME 67 SEPTEMBER 1969 NUMBER 9

The Journal of The KENTUCKY Medical Association



LIBRARY
COLLEGE OF
SEP

In This Issue

Subtotal Gastrectomy Versus Vagotomy and Antrectomy
Romeo S. Berardi, M.D. 659

Detection of Asymptomatic Urinary Tract Infection
Nancy H. Holland, M.D., Roger Jurichs and Gil Clemons 662

Estimated Prevalence of Chronic Conditions in Kentucky
David L. Kruegel, Ph.D. 665

Flurandrenolone Tape
James W. Bard, M.D. 668

Special Article

The Clinical Associate 677

Complete Contents on page 628

KMA ANNUAL MEETING–September 23, 24, 25
Convention Center–Louisville



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema.

Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

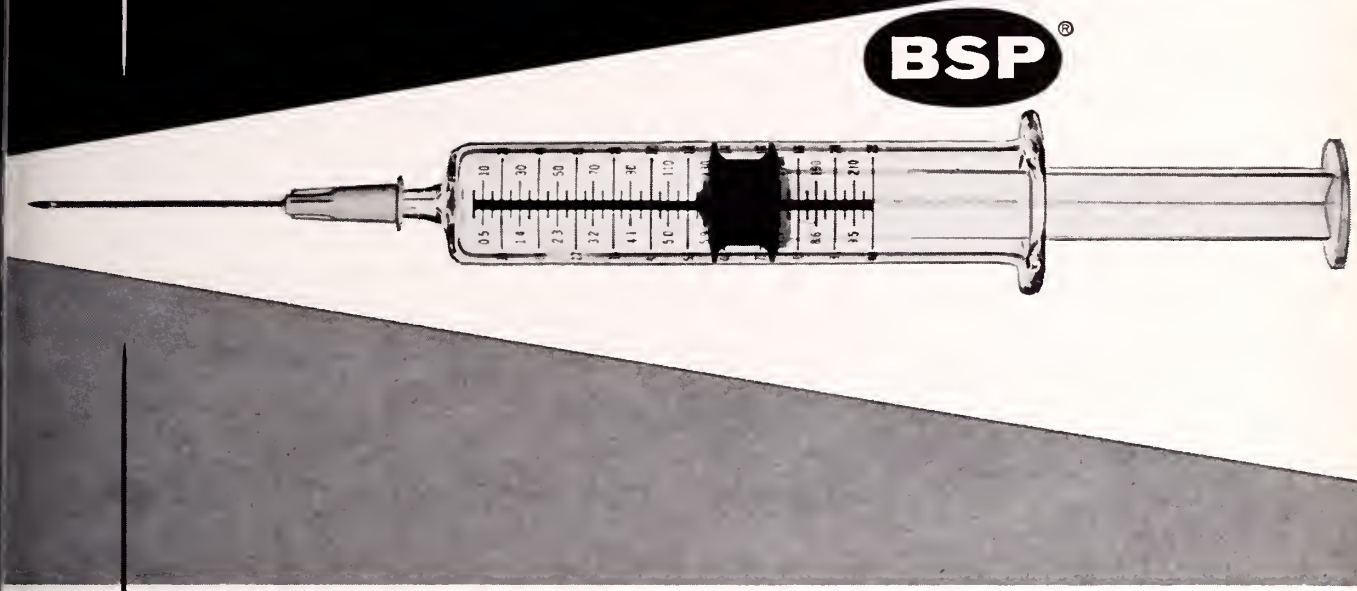
(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/69

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(BSP04)

Volume 67 • September 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Wolter S. Cae, M.D.

• ASSOCIATE EDITOR
Som A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cax

• ASST. MANAGING EDITOR
Dione Maxey

• DEPARTMENTAL EDITORS
Chorles C. Smith, Jr., M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscor J. Hoyes, M.D., Cose Discussions
Willia n W. Hall, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1972
Richard R. Crutcher, M.D.
Chrisman S. Jackson, M.D.
E. Truman Mays, M.D.
Joseph Parker, Jr., M.D.
Elmer G. Prewitt, M.D.
Carl E. Rutledge, Jr., M.D.
Winstan Rutledge, M.D.
A. Franklin White. M.D.

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shroder, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Caverdale, M.D.
William R. Groy, M.D.
Peggy J. Howard, M.D
Ray A. Martin, M.D
Charles R. Perry, M.D.
David C. Shipp, M.D.
John H. Willard, M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The
KENTUCKY
Medical Association

Contents

SCIENTIFIC ARTICLES

Subtotal Gastrectomy Versus Vagotomy and Antrectomy
Romeo S. Berardi, M.D. 659

Detection of Asymptomatic Urinary Tract Infection
Nancy H. Holland, M.D., Roger Jurichs and Gil Clemons 662

Estimated Prevalence of Chronic Conditions in Kentucky
David L. Kruegel, Ph.D. 665

Flurandrenolone Tape
James W. Bard, M.D. 668

SPECIAL ARTICLE

The Clinical Associate 677

EDITORIALS

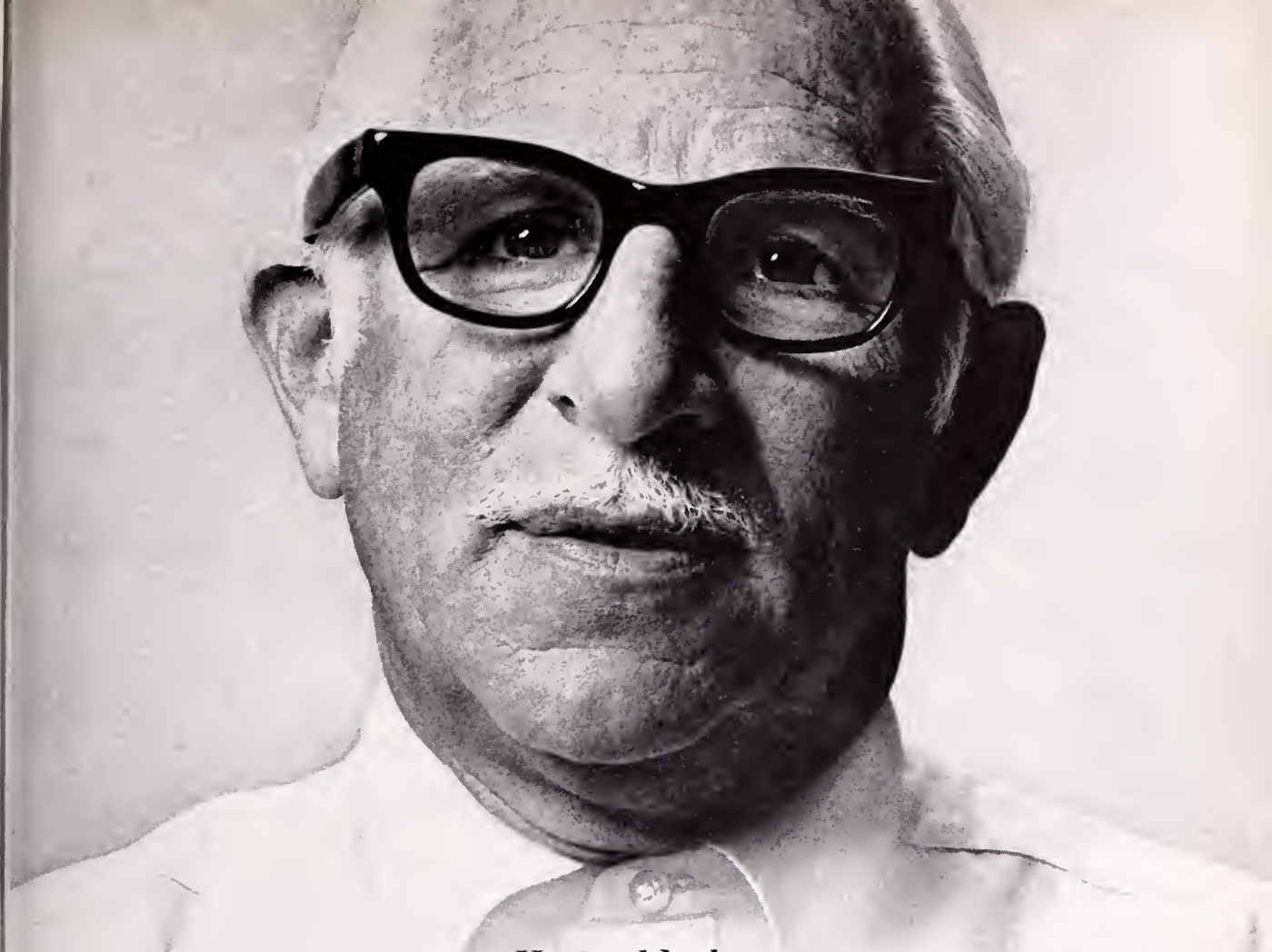
Deans, Then and Now
Sam A. Overstreet, M.D. 688

ORGANIZATION

Crackerbarrel Session, Luncheon Featured at Annual Meeting 693
Reception Planned During Mtg., Given By KMA and Auxiliary 693
KPA Names Glasgow Pharmacist President-Elect at July Mtg. 693
AMA Delegates At Annual Session Consider 196 Business Items 693
AMA Lists 73 Kentucky Physicians at Annual Convention in New York 694
1897 Graduate of UL Med School Dr. Bernard Asman, 97, Dies 694
Miscellaneous Meetings Planned During KMA Annual Meeting 695
Latest "Relative Value Studies" To Be Available October 1 695

REGULAR FEATURES

President's Page 630
Maternal Mortality 634
Postgraduate Opportunities 640
Public Health 648



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



Valedictory: An Impossible Wish!

GRATITUDE—Humility—Awe.

With those sentiments I addressed my first message to you as your President in the October issue of The Journal.

And now, as I compose my last message for this page, those same sentiments are uppermost in my mind.

My gratitude to you for the great honor that has been mine has in no way been lessened during these twelve months. The magnitude and great variety of problems facing the Association, and the frustrations encountered in attempting to solve them, guarantees one's humility. The awesome responsibility of endeavoring to provide the leadership the Association deserves is constantly present and a never-ending reminder of one's human frailties.

As my term draws to a close, I have searched my mind for one last wish—if it were in my power to grant it to the Association. I wish that it were possible for every member of KMA to serve as its president for one month. The responsibility of leadership in dealing with government agencies, third-parties, allied and paramedical groups, as well as the internal functions of the Association, demands study and research which provides an education that can be gleaned in no other way.

Were it possible for my impossible wish to come true, no longer would there be a communication gap between the organization and its members, no longer would there be accusations, based on misunderstanding and mis-information, that the leadership of the Association has "sold out" to the powers of socialized medicine, no longer would there be the large percentage of "non-participating" active members in the affairs of the Association—and a unified, knowledgeable, progressive profession could go forward in search of its goal—to provide the best possible quality medical care to the people of Kentucky.

Henry B. Asman

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

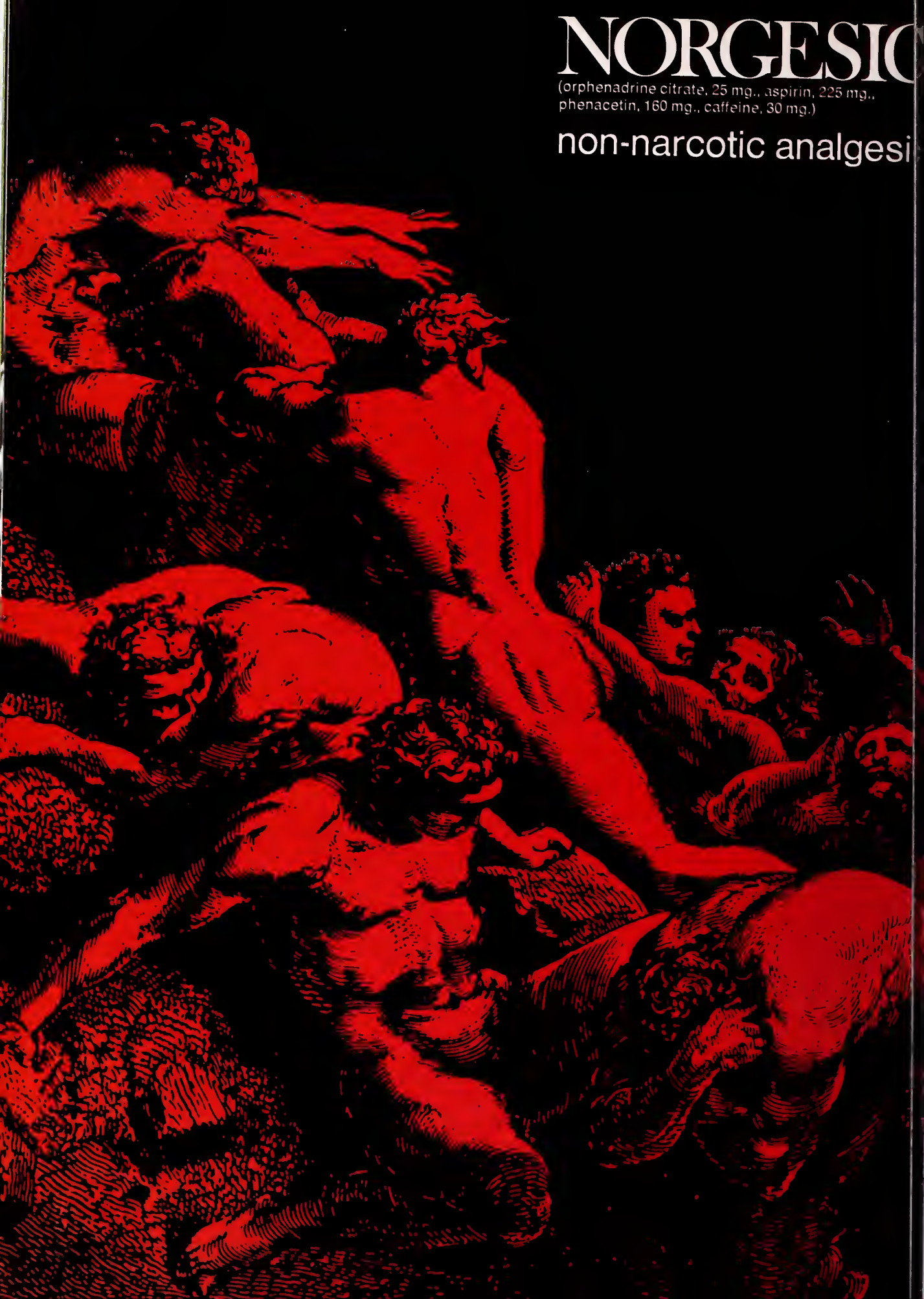
methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS


NORGESIC
(orphenadrine citrate, 25 mg., aspirin, 225 mg.,
phenacetin, 160 mg., caffeine, 30 mg.)
non-narcotic analgesi

musculo-skeletal pain,

Norgesic first...

f 10 patients probably won't ed anything stronger

GESIC offers predictable relief in approxi-ely 80% of patients with painful musculo-letal disorders. It provides *both* effective lgesia and relief of associated muscle sm. NORGESIC works quickly, usually pro-ing a high level of analgesia within two rs, and relief is sustained for four hours or ger.

or the relief of acute mild to moderate pain ociated with musculo-skeletal disorders, NORGESIC first...eight of ten patients proba-won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate of musculo-skeletal origin.
Contraindications: Due to the mild anticholinergic effect rphenadrine, NORGESIC should not be used in patients with coma, pyloric or duodenal obstruction, stenosing peptic rs, prostatic hypertrophy, obstructions at the bladder neck, alasia (megaesophagus), myasthenia gravis or in patients wn to be sensitive to aspirin, phenacetin or caffeine. Do use propoxyphene (Darvon®) concurrently.
Warnings: USE IN PREGNANCY: Since safety of the use of preparation in pregnancy, during lactation, or in the child-ring age has not been established, use of the drug in such ents requires that the potential benefits of the drug be ghed against its possible hazard to the mother and child. USE IN CHILDREN: The safe and effective use of this drug hildren has not been established; therefore, the physician st weigh the benefits against the potential hazards.
Precautions: Recent studies have indicated that prolonged essive use of phenacetin may result in nephrotoxicity. tion should therefore be exercised when administering GESIC to patients with renal insufficiency. It should also be d with caution in patients with tachycardia.
Adverse reactions: Side effects of NORGESIC are those usu-associated with APC or mild anticholinergic agents. These include tachycardia, palpitation, urinary hesitancy or re-tion, dry mouth, blurred vision, dilatation of the pupil, in-ased intraocular tension, weakness, nausea, vomiting, adache, dizziness, constipation, drowsiness, and rarely, icaria and other dermatoses. Infrequently, mental confusion the elderly, mild central excitation and occasional halluci-ions. These mild side effects are usually eliminated by re-ction in dosage. One case of aplastic anemia, with no tablished causal relationship, has been reported.
Dosage and administration: Adults—1 to 2 tablets 3 to 4 es daily.

r more detailed prescribing information, Package Circular or PDR.

NORGESIC®

phenadrine citrate, 25 mg., aspirin, 225 mg., enacetin. 160 mg., caffeine. 30 mg.)

on-narcotic analgesic

ker Laboratories, Northridge, California 91324
, Dart Industries Inc.
onsors of Riker Service—
complimentary classified service for physicians.

Medical Economics says:

GENERAL LEASING'S PLAN IS

"The Winning Way"

TO LEASE A CAR!

SEE ARTICLE, JUNE, 1968 ISSUE,
BY CHARLES WALTER, MIDWEST EDITOR

GENERAL LEASING

is grateful for this tribute to its "Doctor's Lease Plan." Thank you, Doctors, for your participation in the plan which is so formably commented on by Editor Charles Walter in "Medical Economies."

LEASE
Any Make or Model
NEW 1969 CAR

- ★ **Leasing better than buying**
- ★ **No capital investment**
- ★ **Dependable car at all times**
- ★ **Certain tax advantages**
- ★ **Call us for particulars**

LEASE
Medical or Surgical
EQUIPMENT

- ★ **A plan for young doctors**
- ★ **Medical and Surgical equipment**
- ★ **Complete office furnishings**
- ★ **Enlarging facilities**
- ★ **Call us for full details**

PHONES: 897-1641—895-2451

General Leasing Corporation

A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE,
LOUISVILLE, KY. 40207

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 16-67. This 33 year old married white gravida, 3, para 2, was under the care of a private physician. Her prenatal course was uncomplicated until the fifth month of her pregnancy when she complained of chills and fever beginning about 10 a.m on July 10, 1967. Temperature at home was 103°. She remembered nothing of her trip to the hospital.

On admission at 10:50 a.m. she complained of aching and burning all over. Temperature was 106², blood pressure 148/50. An infusion of 1000 cc D_5W with 1 gram of Terramycin was started. A stat CBC and catheterized urine was obtained. She received 2 cc Pyrilgin IM which reduced her fever to 102.6. At 6 p.m. she appeared acutely ill when seen by her physician. There was generalized abdominal tenderness, most acute over the right CVA region and the epigastric area. She was moderately tender over the entire abdomen on deep palpation. Pelvic examination exhibited a marked painful response on palpation of the adnexal region bilaterally. The cervix was long and closed. At 10 p.m. the membranes ruptured spontaneously. There was an extremely foul odor to the amniotic fluid. The patient went into tumultous labor and delivered spontaneously a stillborn male of approximately five months gestation. The placenta was expressed intact and there was minimal bleeding. A vaginal smear was obtained for culture and sensitivity. She was tender over the region of the uterus. Patient's blood pressure ranged 70/50—84/60 for the next two hours. Temperature 98. A Hgb at 8 p.m. was 12 grams, hematocrit 35 per cent. Hypotension was attributed to septic shock rather than from blood loss. An infusion of 1000 cc Trinidex (B Vitamin solution) was started and oxygen given. Solu-Medrol 125 mg was added to the IV. Vasoxyl ½cc was given IM at 4:45 a.m. and ½cc at 5:30 a.m. Her blood pressure remained 70/0, pulse 96-100. She remained anuric. The patient was skin tested for Tetanus antitoxin and gas gangrene. Tetanus antitoxin and gas gangrene antitoxin was given after the skin test was negative. Her condition remained critical. No blood pressure or urinary output was obtained, she expired at 9 p.m. on July 11, 1967.

An autopsy was obtained and the pathologic diagnosis was:

1) Bilateral acute diffuse cortical necrosis of kidney.

2) Bilateral acute hemorrhagic necrosis of adrenal glands.

3) Pulmonary congestion and edema with early bronchopneumonia.

4) Bilateral dilatation of the ventricles of the heart.

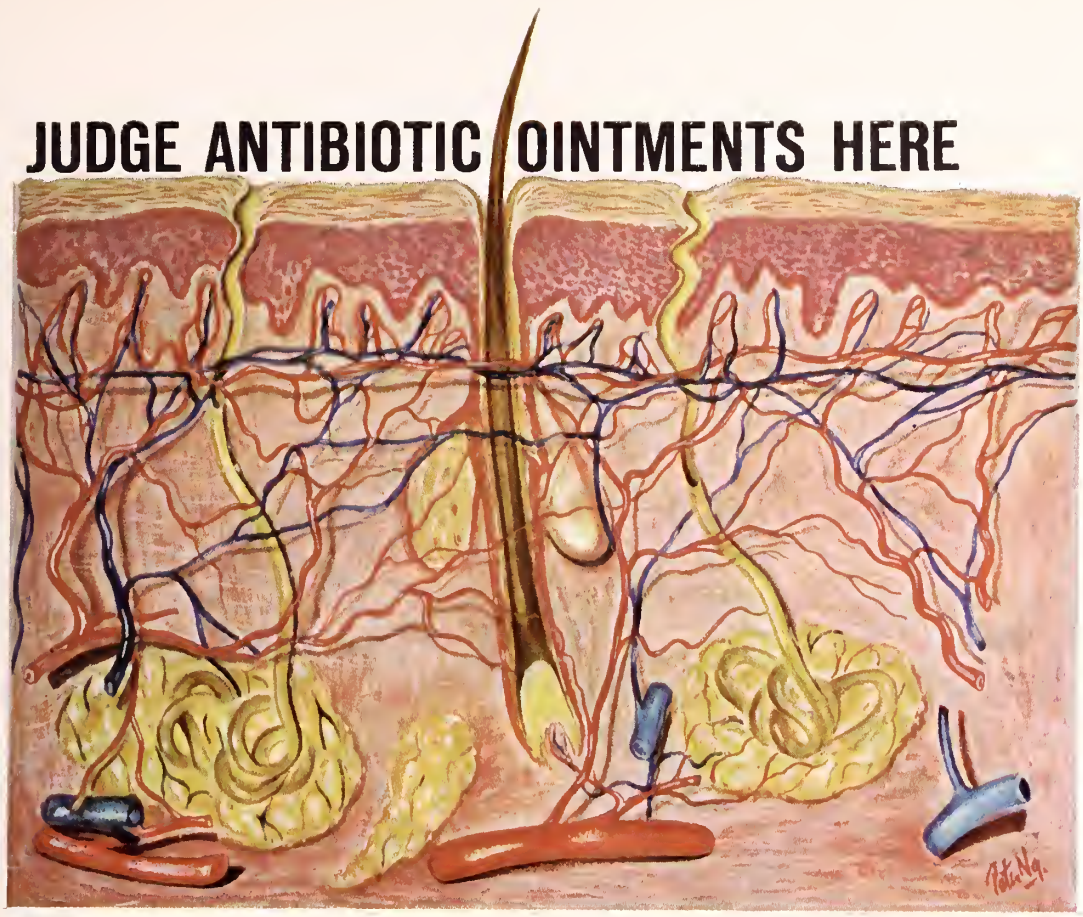
5) Bilateral pleural effusion.

6) Post partum state.

Comment

The Committee classified this as a direct obstetrical death with preventable factors on the part of both the patient and the physician. The patient could have had some criminal attempt to terminate the pregnancy resulting in the infection. On admission further diagnostic procedures should have been done such as chest x-ray, film of the abdomen and intravenous pyelogram. The Committee felt that the treatment of septic shock was not vigorous. Larger doses of antibiotic, glucocorticoid and intravenous fluid should have been used.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

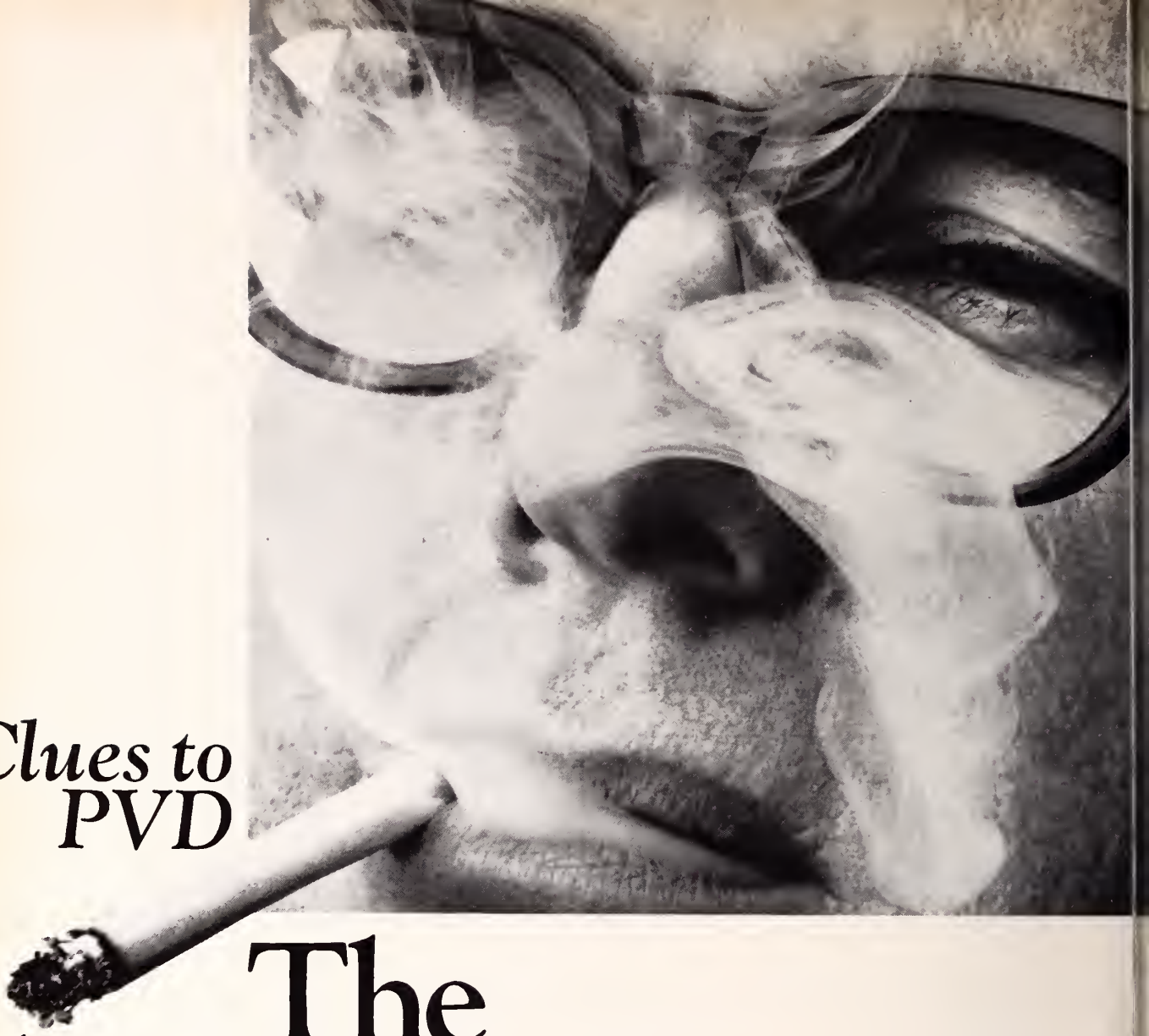
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt —bottles of 50.



Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.



Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Under license from
Boehringer
Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502





They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

Geigy

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

SEPTEMBER

23-25 KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

26-30 Medical Library Association, Brown Hotel, Louisville

29-Nov. 1 Training course on emergency care and transportation of sick and injured persons, sponsored by American Academy of Orthopedic Surgeons, University of Kentucky Medical Center, Lexington

NOVEMBER

6 L. E. Smith Lexture, University of Kentucky Medical Center, Lexington

6-7 Third Annual Newborn Symposium, Department of Pediatrics, University of Louisville School of Medicine, Louisville

7-8 Kentucky Thoracic Society, Fall Scientific Session, Boone Tavern, Berea

13-14 Recent Developments in the Surgical Care of Trauma Program, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

SEPTEMBER

15-16 Congress on Occupational Health, American Medical Association, St. Louis, Mo.

19-20 Great Plains Regional Heart Meeting, University of Iowa, Iowa City, Iowa

24-26 Cleveland Course in Pulmonary Diseases, St. Luke's Hospital, Cleveland, Ohio.

26-Oct. 3 American Academy of General Practice, Philadelphia, Pa.

OCTOBER

3- 4 Conference on Urology, University of Iowa, Iowa City, Iowa.

6-10 Family Practice Symposium, Medical College of Georgia, Augusta, Georgia

13-14 Tennessee Valley Medical Assembly, Memorial Auditorium, Chattanooga, Tenn.

17-18 General Practitioner's In-House Refresher, University of Iowa, Iowa City, Iowa

18-23 American Academy of Pediatrics, 38th Annual Meeting, Palmer House, Chicago, Ill.

23-25 Conference on Surgery, University of Iowa, Iowa City, Iowa

23-25 Southeastern Chapter of the Society of Nuclear Medicine, 10th Annual Scientific Meeting, Sheraton Nashville Hotel, Nashville, Tenn.

31-Nov. 3 Annual Meeting, Association of American Medical Colleges, Cincinnati Convention Center, Cincinnati, Ohio

NOVEMBER

10-13 Southern Medical Association, 63rd Annual Meeting, Atlanta, Ga.

12-15 Third Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach", Tides Hotel and Bath Club, Redington Beach, Florida.

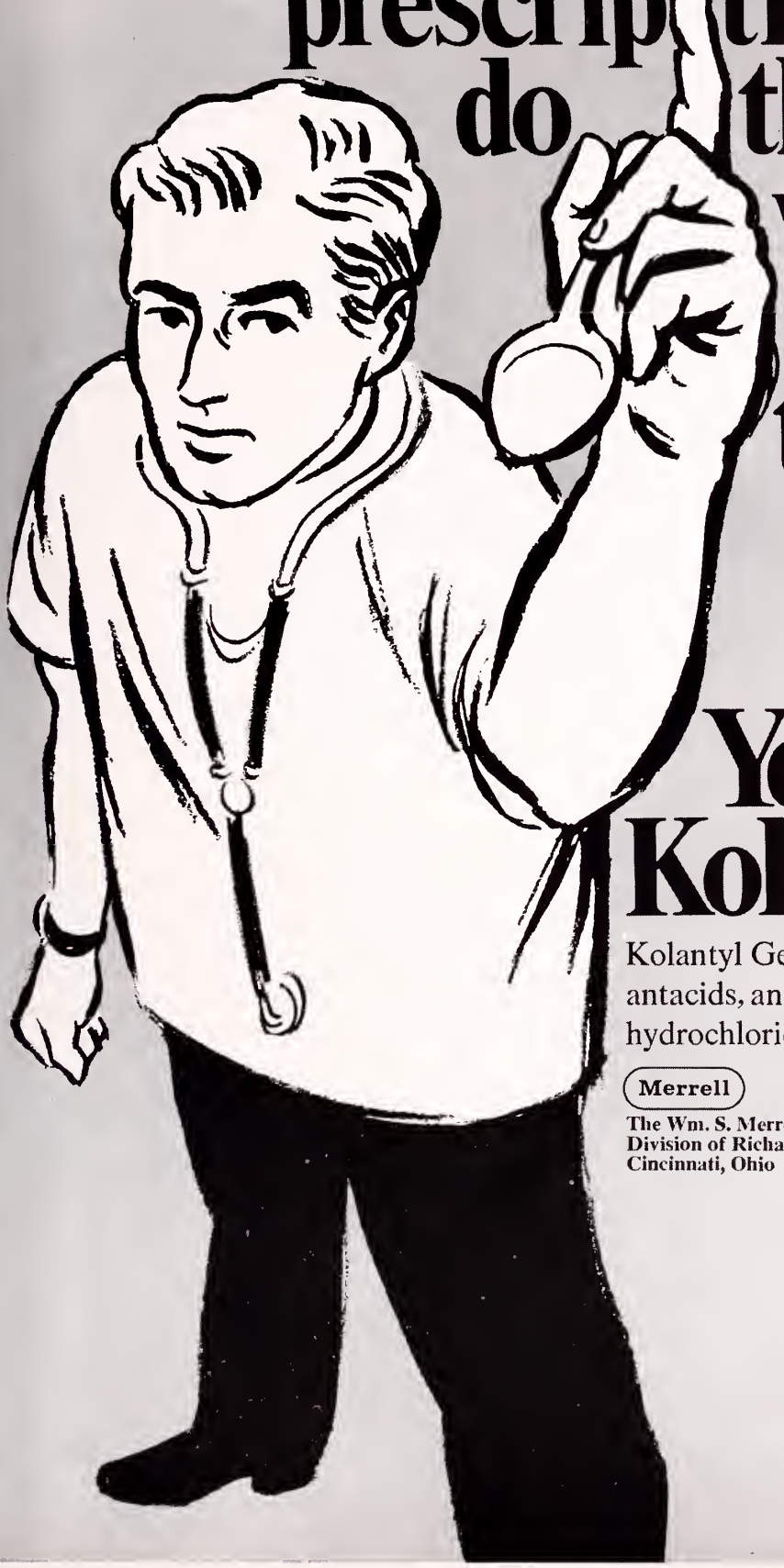
SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

OFTEN... HER LOWER G. I. TRACT



Psycho-abdominal Distress: Frequently Female

Women aged 15 to 45 appear to be more prone than men to bloating, cramping pain of stress-related intestinal disturbances such as irritable or spastic colon.[1,2]

Frequently Recurrent

In the experience of many physicians, women are more likely to reappear time after time with repeated complaints of lower G.I. distress.

Requiring Definitive Therapy

Often needed is therapy adequate to control both the somatic and the emotional components of psycho-abdominal complaints.

Definitive Dual Therapy

'Milpath' contains a proven synthetic anticholinergic useful for relieving hypermotility, spasm, and hypersecretion of the gastrointestinal tract.

In addition, 'Milpath' provides a time-tested tranquilizer for mild but effective anti-anxiety action.

With Flexible Dosage

- 'Milpath'-400 (meprobamate 400 mg. + tridihexethyl chloride 25 mg.) Usual adult dose: 1 tablet *t.i.d.* and 2 at bedtime.
- **When less tranquilization is required: 'Milpath'-200 (meprobamate 200 mg. + tridihexethyl chloride 25 mg.)**

Wallace Pharmaceuticals/ Cranbury, N. J. 08512

gently but firmly

MILPATH®

(meprobamate + tridihexethyl chloride)

relaxes smooth muscle and psyche

Please see the following page for brief summary of prescribing information.

Gently but firmly MILPATH®

(meprobamate + tridihexethyl chloride)

Relaxes smooth muscle and psyche



Usual Adult Dosage

One 'Milpath'-400 tablet, three times a day at mealtimes, and two at bedtime. For greater anticholinergic effect, two 'Milpath'-200 tablets, three times a day at mealtimes and two at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.

Indications

Useful in organic and functional disorders with hypersecretion and hypermotility of G.I. tract, especially when accompanied by anxiety, neurosis, or tension states. Should be used as an adjunct to all other therapeutic measures.

Contraindications

Tridihexethyl chloride: Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus: organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention.

Meprobamate: Previous allergic or idiosyncratic reactions to meprobamate.

Precautions

Tridihexethyl chloride: Use cautiously in elderly males (possible prostatic hypertrophy).

Meprobamate: Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (one or two weeks) after excessive dosage for weeks or months to avoid recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.

Side Effects

The following side effects of components may occur with 'Milpath'.

Tridihexethyl chloride: Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness.

Meprobamate: Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after one to four doses); in mild form: itchy, urticarial or erythematous, maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and one fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (one fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, one fatal aplastic anemia reported, but only in presence of known toxic drugs, porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by one observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported.

Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.

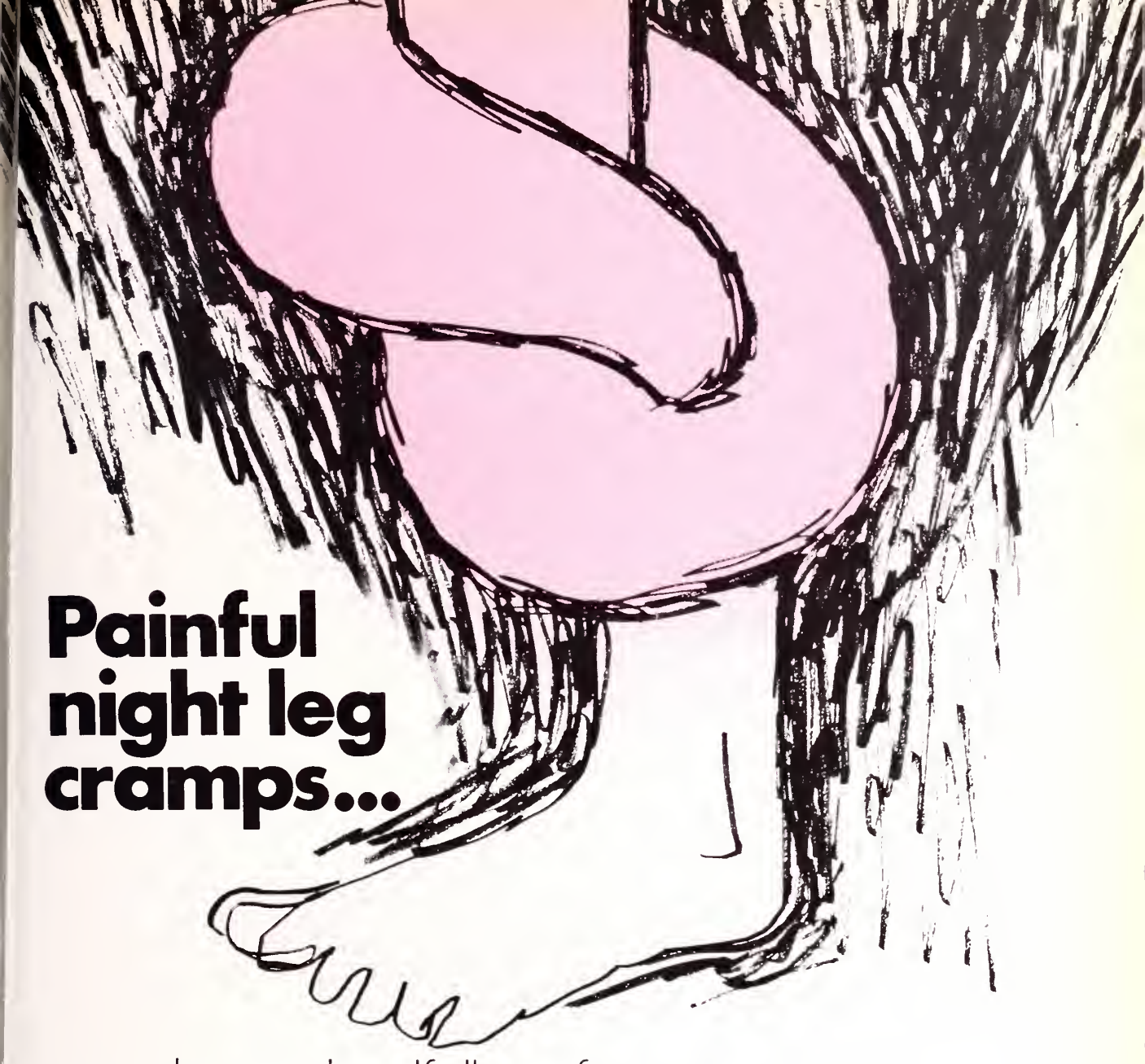
Supplied

In two strengths:
'Milpath'-400: Yellow, scored tablets.
'Milpath'-200: Yellow, coated tablets.
Before prescribing, consult package circular.

References

1. Harrison, T. R., et al.: Principles of Internal Medicine, Fifth Edition, New York, The Blakiston Division, McGraw-Hill Book Company, 1966, p. 1019. 2. Bockus, H. L.: Gastroenterology, Second Edition, Philadelphia & London, W. B. Saunders Company, 1964, Vol. II, p. 729 et seq.

(1928A01J)



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

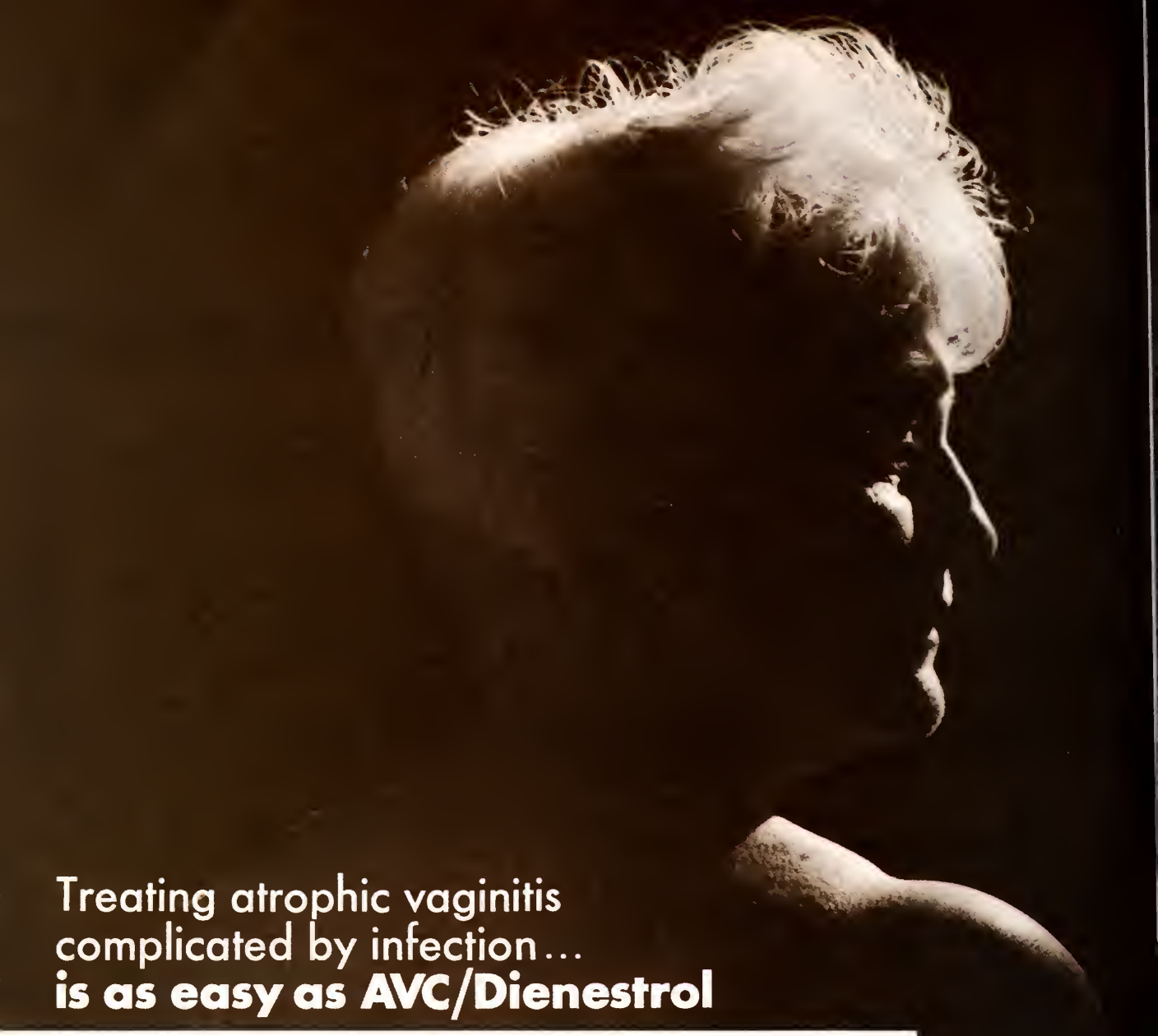
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Infarmatian—Campasitian: Each white, beveled, compressed toblet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indicatians:** For the prevention and treatment of nacturnal ond recumbency leg muscle cramps, including those associated with arthritis, diabetes, voricase veins, thrombophlebitis, arteriosclerosis ond stotic faat deformities. **Contraindicatians:** QUINAMM is controlndicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cromps in some instonces, and quinine may produce symptoms af cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discantinue use if ringing in the eors, deafness, skin rosh, or visual disturbances accur. **Dasage:** One tablet upon retiring. Where necessory, dosage may be increosed to ane tablet fallowing the evening meal ond one tablet upon retiring. **Supplied:** Bottles of 100 and 500 toblets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., ominaphylline 195 mg.)



Treating atrophic vaginitis complicated by infection... **is as easy as AVC/Dienestrol**

Dienestrol helps restore estrogen-deficient vaginal mucosa.
It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfonamides; diagnosis or familial history of carcinoma of the genital tract or breasts; precarcinomatous lesions of the vagina or vulva; palpable uterine fibromyoma; mammary fibroadenoma; depressed liver function.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC/Dienestrol

Cream (dienestrol .01%, sulfonilomide 15.0%, ominocrine hydrochloride 0.2%, allontoin 2.0%)
Suppositories (dienestrol 0.70 mg., sulfonilomide 1.05 Gm., ominocrine hydrochloride 0.014 Gm., allontoin 0.14 Gm.)

TRADEMARK A V C AV-920A 7/69

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681

PUBLIC HEALTH PAGE

Rabies in Kentucky - A Current Crisis*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE probability of transmission on rabies virus from infected animals to human beings is perhaps now greater in Kentucky than in any other state in the nation. During the past four years a growing epizootic of fox rabies has spread across the Commonwealth with increasing incidence in other animal species and an alarming number of human exposures. In 1968 Kentucky led the entire United States in total number of laboratory confirmed cases of animal rabies, total fox cases, total cattle cases and total dog cases. During the same period more than 5,000 doses of human antirabies vaccine were shipped from the Vaccine Depot of the State Department of Health via local health units to physicians throughout the Commonwealth.

In some epidemic areas individual practitioners have had as many as ten or more persons undergoing antirabies therapy at the same time! The problem is compounded by the fact that a continuation of the current rabies crisis has been predicted. It therefore behooves every Kentucky physician to familiarize himself with several important aspects of rabies epidemiology and human prophylaxis.

Animal Reservoirs

All warm blooded animals are susceptible to rabies virus. Some species (e.g., cattle) are unusually susceptible; others (e.g., opossums) are highly resistant. Once infected, some species (e.g., skunks) shed unusually large quantities of virus in their saliva; others (e.g., rodents) seldom become salivary shedders. Such facts have obvious bearing on the question of whom should receive antirabies therapy, especially when the offending animal has escaped and no clinical or laboratory observations can be made.

Currently foxes (both red and gray) are the primary reservoirs of rabies virus in Kentucky. Although outright attacks on man are relatively uncommon, they do occur. However, foxes effectively transmit the virus to domestic animal species which in turn have a far greater opportunity to expose large numbers of people. The following table will be helpful in gaining further insight into this facet of the problem. Almost all submissions represent one or more human exposures, chiefly bite wounds.

Seasonal Distribution

Contrary to popular belief rabies is *not* more prevalent during hot weather. In Kentucky the incidence of animal rabies is lowest in the summer, begins to increase in the fall and peaks during the late winter and spring months. However, the incidence of animal bites *per se* is highest during the warmer seasons of the year, probably as a result of increased outdoor activity by man.

Geographic Distribution

During calendar year 1968 there was at least one case of laboratory confirmed animal rabies in no less than 59 of Kentucky's 120 counties! Although the largest epizootics of fox-centered rabies occurred north of the cave region in and around Hardin, Breckenridge, Meade, Hancock and Daviess counties, no section of the state was entirely free of cases. Continuing outbreaks are likely to occur anywhere there are abundant populations of susceptible animals, especially foxes, skunks and unvaccinated dogs and cats.

Diagnosis

Symptoms of rabies vary with the species in question and individuals within the species. Since rabies generally cannot be differentiated clinically from a host of other encephalitides, laboratory examination of the brain is essential for a definitive diagnosis. Complete rabies diagnostic services including Negri body examination, fluorescent antibody testing and mouse inoculation are available free-of-charge at the State Health Department. Specimens are exam-

*This article was prepared by: *Joseph W. Skaggs, D.V.M., M.P.H., Office of Communicable Diseases, Division of Epidemiology, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky 40601.*

Animal Rabies Specimens, by Species and Laboratory Results
Kentucky, 1968

Species	Foxes	Cattle	Dogs	Cats	Swine	Bats	Skunks	Horses	Others	Total
No. Exam.	317	145	465	267	18	97	21	25	230	1,585
No. Pos.	213	76	62	21	4	5	14	17	1	413
Percent Pos.	67.2	52.4	13.3	7.1	22.2	5.1	66.7	68.0	0.4	26.1

ined on an emergency basis seven days a week and preliminary reports are usually telephoned within 24 hours of receipt. Specially designed shipping containers for animal specimens are available at every local health department in the state.

Biting animals should be captured, quarantined and observed for signs of CNS disease. In Kentucky the official quarantine period is 14 days. However, if the animal has rabies virus in his saliva at the time of the biting incident it would almost invariably have to be symptomatic within five days. If the animal should die or must be sacrificed, the head should be severed and shipped in ice immediately to the laboratory.

Prevention of rabies in an exposed person

Immediate, thorough flushing and cleansing with soap of all animal bite wounds is perhaps the most effective means of preventing rabies. Quartenary ammonium compounds may also be of value provided all traces of soap are removed prior to application. From the viewpoint of rabies prevention, suturing of the wound or other form of primary closure is not advised. Of course, tetanus prophylaxis and measures to control bacterial infections should be applied as indicated.

Most authorities agree that inactivated, fixed rabies virus prepared from infected embryonated duck eggs is the vaccine of choice currently marketed in the United States. It is perhaps slightly less antigenic, but more rarely the cause of neuroparalytic reactions than the traditional nervous tissue origin (Semple type) vaccines. However, mild-to-severe allergic reactions can occur, usually late in the course of therapy. At least 14 single daily injections are administered subcutaneously, rotating the sites as indicated. For severe exposures (e.g., multiple bite wounds especially around the head, face and neck), at least 21 doses are recommended. In addition, 1,000 units of rabies hyperimmune serum (equine origin) per 40 pounds of body weight and two booster doses of vaccine, one 10 days and the other at least 20 days after completion of the primary 14 or 21 dose series, are advised for the best, most complete post-exposure prophylaxis. Such therapy should be instituted as early as possible especially in instances where a short incubation period is feared. At least seven doses of duck embryo rabies vaccine are always on hand and available to any physician who requests them at every local health department in the state. In addition, rabies hyperimmune serum can be delivered from the State Health Department Vaccine Depot to any practitioner within a matter of hours.

The above guide which takes into account the species of biting animal, its status at the time of the attack and the severity of exposure should be referred to in determining the need for post-exposure antirabies therapy:

Pre-exposure Prophylaxis

Kentucky veterinarians, animal handlers, certain laboratory workers and others whose vocational or avocational pursuits lead to frequent contact with potentially rabid dogs, cats, livestock or wildlife (including bats) should be considered for pre-exposure antirabies prophylaxis. Either of two schedules for pre-exposure administration of the duck embryo vaccine are currently recommended:

1. Two 1.0 ml. injections subcutaneously in the deltoid area 1 month apart followed by a third dose six to seven months later.

2. Three 1.0 ml. injections as above at weekly intervals with a fourth dose three months later.

Sero-conversion rates achieved by these schedules approach 80-90 per cent within one month after the final dose. In either instance a 2-3 ml. sample of the vaccinee's serum should be sent to the State Health Department for titering for rabies neutralizing antibody approximately one month after the last dose in the series. Results currently require about six weeks. If antibody is not detectable, booster doses of vaccine should be given until sero-conversion occurs. Continuing immunity can and should be maintained with single 1.0 ml. boosters at two to three year intervals.

If a person so protected should suffer a bonafide exposure to rabies virus, then additional boosters are immediately recommended as follows: mild exposure, one booster dose; severe exposure, five daily doses of vaccine plus a booster dose 20 days later.

Many Kentucky veterinarians and animal diagnostic laboratory workers are currently on the above regimen of continuing rabies immunization and have documented neutralization indices for rabies antibody. However, if it is not definitely known that an exposed person has measurable antibody, a complete post-exposure treatment should be given.

Final Comments

Many significant advances have been made during recent years in the study, prevention and control of rabies. Some have not received mention in this article

Guide For Post-Exposure Antirabies Prophylaxis[2]

The following recommendations are intended only as a guide. They may be modified according to knowledge of the species of biting animal and circumstances surrounding the biting incident.

Biting Animal		Treatment		
			Exposure	
Species	Status at Time of Attack	No Lesion	Mild*	Severe*
Dog or Cat	healthy	none	none[1]	S[1]
	signs suggestive of rabies	none	V[2]	S+V[2]
	escaped or unknown	none	V	S+V
	rabid	none	S+V	S+V
Skunk, Fox, Raccoon, Coyote, Bat	regard as rabid in unprovoked attack	none	S+V	S+V
Other	consider individually—see Rationale of Treatment in text			

Code: *=See definitions in text.
V=Rabies Vaccine
S=Antirabies Serum
1=Begin vaccine at first sign of rabies in biting dog or cat during holding period (preferably 7-10 days).
2=Discontinue vaccine if biting dog or cat is healthy 5 days after exposure, or if acceptable laboratory negativity has been demonstrated in animal killed at time of attack. If observed animal dies after 5 days and brain is positive, resume treatment.

(e.g., the discovery that rabies virus can be transmitted via aerosols). In addition, a great deal of meaningful research is now underway to develop safer, more effective immunizing agents for both man and animals and to discover more practical means for the control of the disease in wildlife species.

Kentucky's last human rabies cases occurred in 1961 when two persons bitten by rabid foxes died in the eastern part of the state. One represented a frank vaccine failure; the other was a tragic example of what can happen when specific antirabies therapy is delayed.

We are fortunate that no human rabies deaths have occurred during the current epizootic. Physician awareness of what constitutes a rabies exposure and how to deal with one when it occurs will hopefully result in a continuation of our good fortune.

Inquiries concerning rabies epidemiology, treatment, diagnostic service and control programming should be directed to the Office of Communicable Diseases, Kentucky Department of Health, telephone (502) 564-4935.

References

1. World Health Organization Technical Report Series, 1966, No. 321.

2. Public Health Advisory Comittee on Immunization Practices: Guide for Post-Exposure Antirabies Prophylaxis. (Reprinted from the Morbidity and Mortality Weekly Report, Vol. 16, No. 19, week ending May 13, 1967).

Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

Parke, Davis & Company, Detroit, Michigan 48232

56569

now he can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

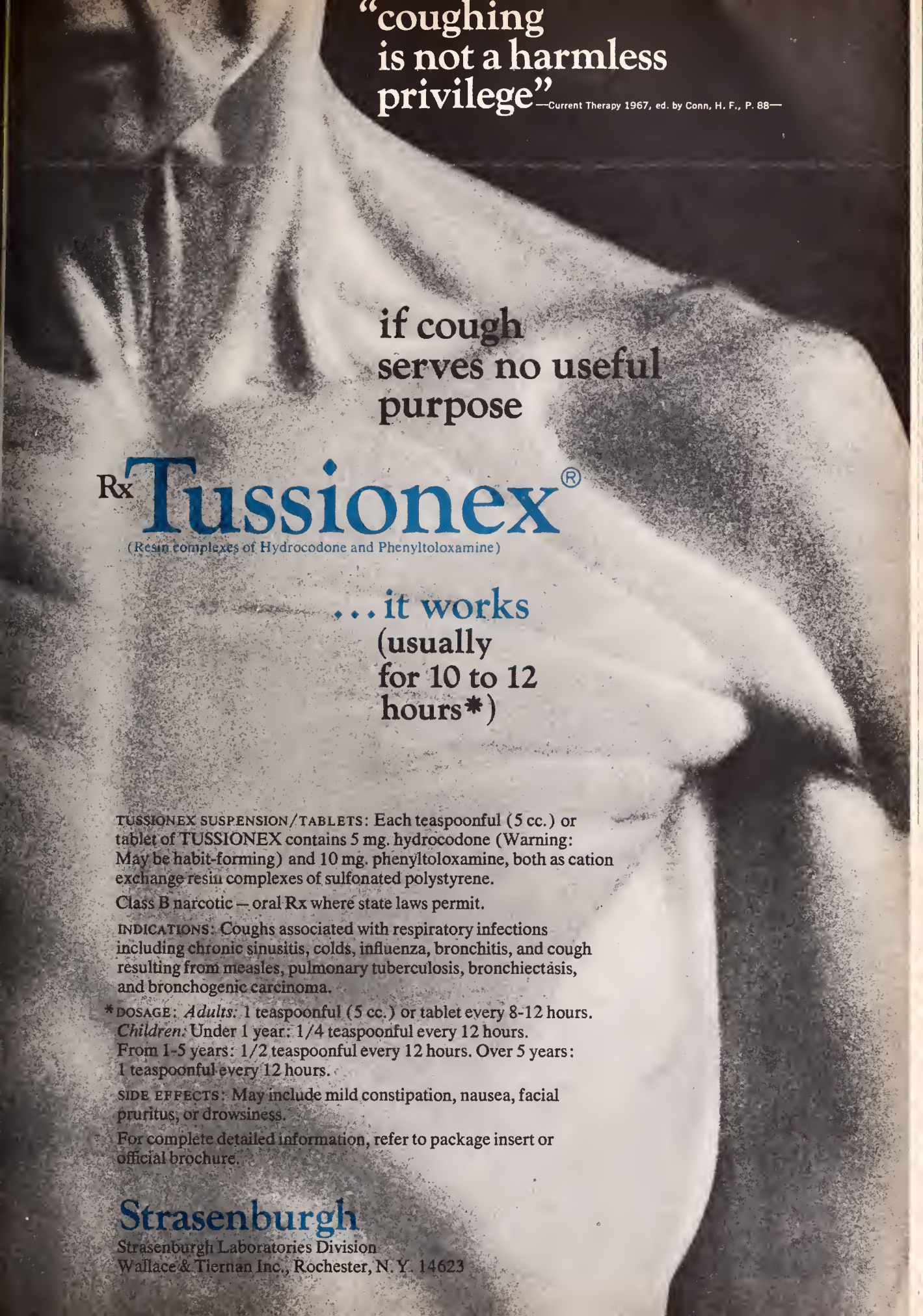
Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS®[Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.




"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
Rx Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic — oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623


No place for beginners

Terramycin®
oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

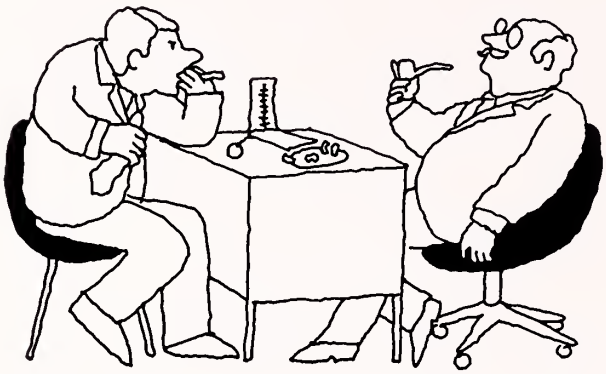
Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

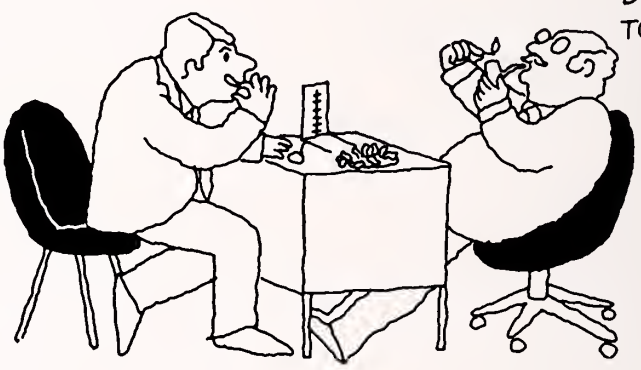
Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

The Apprehensive Hypertensive



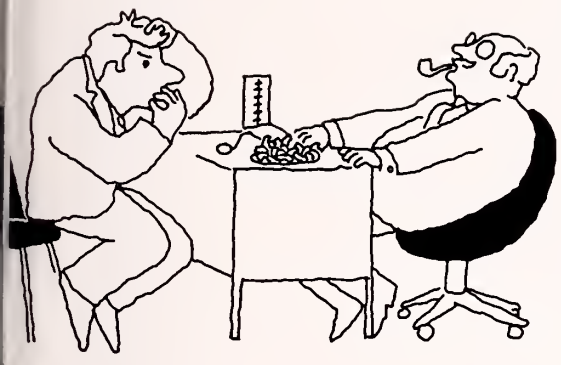


Regroton® to lower blood pressu

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Inc
respiratory secretions, nasal congestion, cyanosis and anorex
occur in infants born to reserpine-treated mothers. *Precautions:*
pertensive therapy with this drug should always be initiated ca
in postsympathectomy patients and in patients receiving gan
blocking agents, other potent antihypertensive drugs, or curare.
dosage of concomitant antihypertensive agents by at least one-h
avoid hypotension during surgery, discontinue therapy with this
two weeks prior to elective surgical procedures. In emergency s
use, if needed, anticholinergic or adrenergic drugs or other sup
measures as indicated. Because of the possibility of progres
renal damage, periodic kidney function tests are indicated. Disc
if the BUN rises or liver dysfunction is aggravated. Hepatic com
be precipitated. Electrolyte imbalance, sodium and/or potassiu
pletion may occur. If potassium depletion should occur during th
the drug should be discontinued and potassium supplements
provided the patient does not have marked oliguria. Take particula
in cirrhosis or severe ischemic heart disease and in patients rec

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



WE'VE GOT PROBLEMS.



nd allay anxiety in hypertension

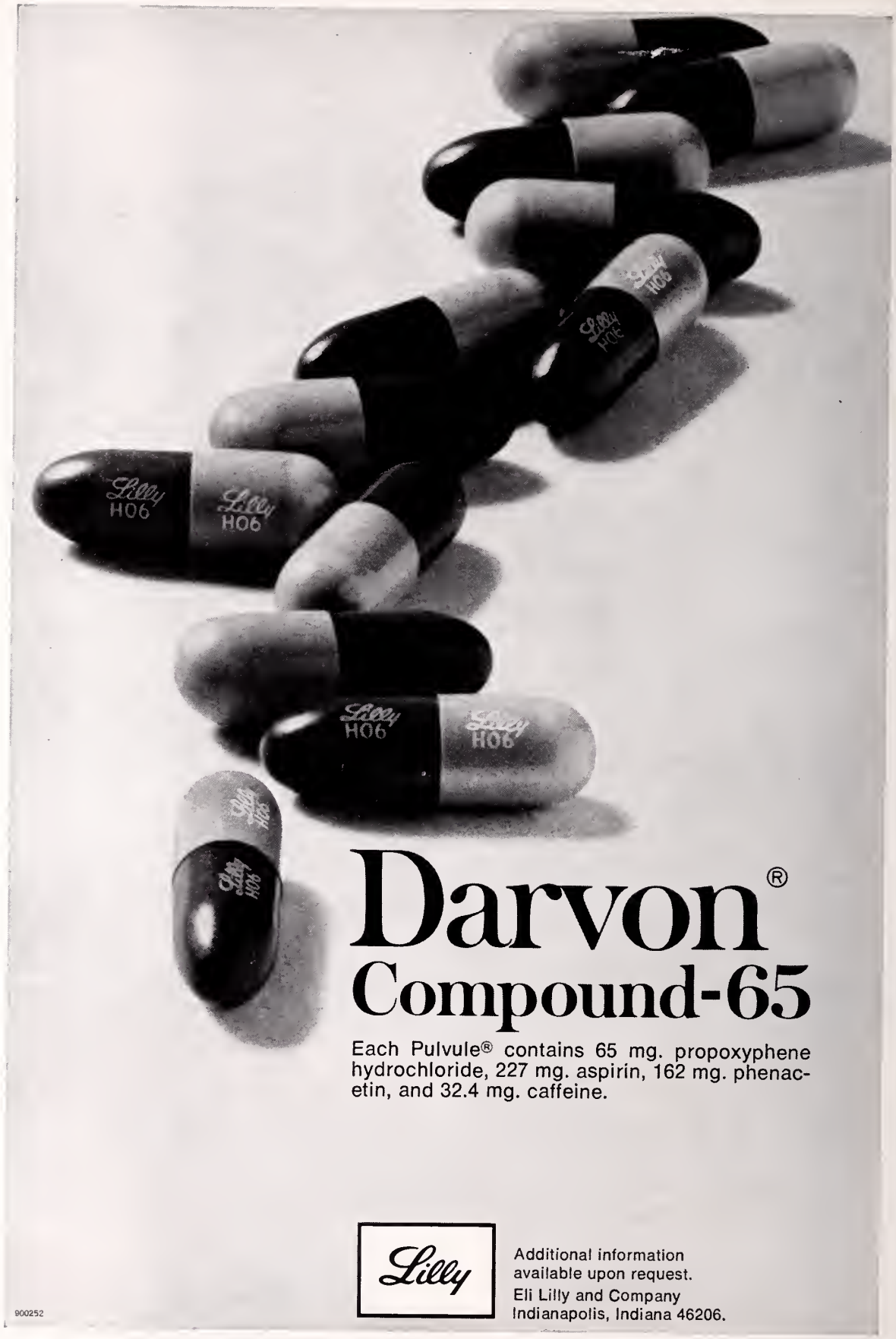
teroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (colic may be precipitated). Bronchial asthma may occur in ble patients. *Adverse Reactions:* The drug is generally well l. The most frequent side effects are nausea, gastric irritation, , diarrhea, constipation, muscle cramps, headache, dizziness te gout. Other potential side effects include angina pectoris, depression, bradycardia and ectopic cardiac rhythms (espe- nen used with digitalis), drowsiness, dull sensorium, hyperglynd glycosuria, hyperuricemia, lassitude, restlessness, transient impotence or dysuria, orthostatic hypotension which may be ted when chlorthalidone is combined with alcohol, barbiturates otics, leukopenia, aplastic anemia, skin rashes, thrombocytogranulocytosis, nasal stuffiness, increased gastric secretions, re, purpura, urticaria, ecchymosis, weakness, uveitis, optic and glaucoma, and pruritus. Eruptions and/or flushing of the reversible paralysis agitans-like syndrome, blurred vision, con- injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 SEPTEMBER, 1969 No. 9

Subtotal Gastrectomy Versus Vagotomy and Antrectomy In the Treatment of Duodenal Ulcer, A Comparative Study

ROMEO S. BERARDI, M.D.*

McDowell, Kentucky

A comparative study of subtotal gastrectomy and vagotomy-antrectomy is presented. The results show a persistent and consistent superiority of vagotomy and antrectomy in the treatment of chronic duodenal ulcer.

IN 1962, a 10 year follow-up study was conducted detailing the results of 118 consecutive subtotal gastrectomies (SG) performed by the same surgeon (E.C.) for the treatment of duodenal ulcer[1]. This was by far the most popular procedure at that institution during the considered study period. Since 1964 this author has employed vagotomy and antrectomy for the treatment of most duodenal ulcers and during a four year period, 1964-1968, a total of 50 such procedures have been performed. This paper is a comparative study of these two groups of patients.

Clinical Data and Methods

The age distribution was essentially the same in either group with the majority being between 45-55 years. The male-female ratio approximated 4:1 in both series. The indications for surgery in the SG group were as follows: Bleeding, 54 patients (45.8 per cent); Obstruction, 16 patients (13.5 per cent) and Intractability, 48 patients (40.7 per cent). In the VA group, there were 30 patients with intractability (60 per cent); 11 patients with obstruction (22 per cent); and nine patients with bleeding (18 per cent). Acute perforations are not being considered.

The SG group consisted of 118 consecutive patients whereas the VA group included patients for whom this procedure was deemed the most feasible and physiologic under the presenting circumstances. Whenever a VA was decided against, either a vagotomy and pyloroplasty (VP) or gastroenterostomy (VG) was performed. During this study period 17 VP's and nine VG's have been performed.

At least a 70 per cent resection was carried out in the SG group with gastrointestinal continuity being reconstructed by a retrocolic Hofmeister gastrojejunostomy. In the VA group, along with the vagotomy, no more than 25 per cent of the distal stomach was removed with gastrointestinal continuity being reconstructed by an antecolic Polya gastrojejunostomy[12].

Most patients (84 per cent) in the VA group had preoperative and postoperative acid

*Chief of Surgery, Appalachian Regional Hospital, McDowell, Kentucky

studies. The follow-up program consisted in recall at 3, 6, 12, 36 and 48 months. Studies were first carried out at each visit and included acid studies, Hollander test, histamine gastric analysis, stools for occult blood, upper gastrointestinal radiologic series, besides a routine physical. However, for the past two years, these studies have been carried out only during the six month recall visit as a routine, but may be performed during any visit in the follow-up program, if and when indicated.

The follow-up program in the SG group consisted primarily of patients completing a questionnaire form which was sent to them, although a small percentage was interviewed and examined. No acid studies were carried out and an upper gastrointestinal barium study was obtained only if indicated.

In both series, each patient's weight, eating, smoking and drinking habits were recorded. The presence or absence of diarrhea and/or symptoms of dumping were noted. All patients were asked whether they thought the operation helped them. Restoration to former employment was also ascertained.

Results

SG Group:

a. 84.7 per cent responded to the questionnaires.

b. The immediate postoperative mortality and morbidity rates were 2.5 per cent and 6.7 per cent respectively.

c. 57 per cent lost weight and 30 per cent gained weight.

d. 41.3 per cent had some form of the dumping syndrome but in only 3.2 per cent were the symptoms considered severe.

e. 57.5 per cent had to leave work preoperatively for a variable period of time and only 8.7 per cent postoperatively.

f. 7.6 per cent had some form of postoperative bleeding.

g. 9.3 per cent experienced diarrhea postoperatively.

h. 30.5 per cent stated that it was necessary to lie down after eating. This varied from an occasional heavy meal to most ordinary meals.

i. All patients stated they either wished they were operated on sooner or that the operation helped them.

j. A recurrent ulcer was definitely established in one case (0.8 per cent).

VA Group:

a. 100 per cent have been followed.

b. The immediate postoperative mortality and morbidity rates were 0 per cent and 14 per cent respectively.

c. All patients either gained weight or stabilized their weight with the exception of one who purposely was placed on a weight reducing diet.

d. 8 per cent had some form of the dumping syndrome. None was severe and all were easily controlled by diet alone.

e. All patients who were working preoperatively returned to their former employment.

f. No patient experienced any type of postoperative bleeding.

g. 4 per cent experienced postoperative diarrhea.

h. 92 per cent rapidly returned to their normal eating habits.

i. All patients stated they either wished they were operated on sooner or that the operation helped them.

j. 6 per cent were found to have postoperative free HCl. Two were subnormal and the third within normal range. All three are asymptomatic.

k. No recurrent ulcer has been detected to date.

Discussion

From the early 1930's to the late 1950's the procedure of choice by far for the treatment of chronic duodenal ulcer was subtotal gastrectomy[2-7]. In recent years the pendulum has definitely swung to vagotomy and a drainage procedure or limited resection[8-14]. Although the results of subtotal gastrectomy were much superior to those of simple gastroenterostomy, they were by no means acceptable to all[15] even though reports from certain quarters remain excellent[16].

With the advent of vagotomy plus, results are beginning to show a definite and consistent superiority. The ulcer patient today is much better off from a surgical point of view than ever before.

Although it is still too early to definitely establish an accurate recurrent ulcer rate in the VA group, the other parameters considered have shown a distinct improvement over

the SG group. Postoperative complications have been markedly lowered. We are no longer confronted with severe "dumper's" nor with weight problems. Restoration to preoperative normal habits and activities is more certain. The two patients who experienced postoperative diarrhea in the VA group were treated symptomatically and improved without difficulty.

The postoperative morbidity rate was somewhat higher in the VA group (14 per cent vs 6.7 per cent). This is explained by the fact that all major and minor complications were included whereas only major complications were considered in the SG group. The mortality in the SG group was of a cardiopulmonary nature in three and postoperative acute pancreatitis in one.

The selection of patients in the VA group certainly accounted for some of the improvement. We do not hesitate to employ vagotomy and pyloroplasty or gastroenterostomy in other selected cases. As a matter of fact during this same study period such procedures were performed in 17 cases and nine cases respectively. Although we prefer vagotomy and antrectomy, whenever the following criteria are met, a lesser procedure is carried out.

Criteria for vagotomy and pyloroplasty:

a. Relative low acid determinations (20-40 meqs/1.).

b. Minimal disease found at operation with a relatively mobile duodenum.

c. Should the patient have an hiatal hernia and/or gall bladder disease with a duodenal ulcer, then this procedure is usually performed.

d. Weight is essentially of no concern.

e. Whenever the risk of resection outweighs its advantages.

Criteria for vagotomy and gastroenterostomy:

a. In the severely obstructed and edematous duodenum.

b. In the severely scarred and fixed duodenum.

c. The age of the patient.

d. Whenever the risk of resection outweighs its advantages.

e. Acid studies do not influence us in the choice of this operation.

In all other cases and therefore in the majority, vagotomy and antrectomy is the procedure of preference.

Summary

A comparative study of subtotal gastrectomy and vagotomy-antrectomy in the treatment of chronic duodenal ulcer has been presented. The results of vagotomy and antrectomy are superior and is the procedure of preference for most cases of chronic duodenal ulcer. Criteria for vagotomy and pyloroplasty or gastroenterostomy, as used by this writer, have been enumerated.

References

1. Croce, E. and Berardi, R. S.: Subtotal gastrectomies in the treatment of chronic duodenal ulcer. 10 year follow-up. Paper delivered before the Worc. Surg. Forum. Worchester, Mass, 1962.
2. Berg, H.A.: The radical cure of gastric and duodenal ulcer. *S. Cl. North America.* 5: 49, 1925.
3. Walters, W.: Developments in peptic ulcer surgery at the Mayo Clinic. *Arch. Surg.* 82: 260, 1961.
4. Harvey, H.D., St. John, F.B. and Volk, H.: Peptic ulcer. Late followup results after partial gastrectomy: Analysis of failures. *Ann. Surg.* 138: 680, 1953.
5. Allen, A.M. and Welch, C.E.: Subtotal gastrectomy for duodenal ulcer. *Ann. Surg.* 124: 688, 1946.
6. Gary, H.K. and Williams, R.R., Jr.: Results of classic operations for duodenal ulcer: 5 to 10 year follow-up in 532 cases. *J.A.M.A.* 141: 509, 1949.
7. Moore, F.D., Peete, W.P.J., Richardson, J.E., Erskine, J.M., Brooks, J. R. and Rogers, H.: Effect of definitive surgery on duodenal ulcer disease: Comparative study of surgical and non-surgical management in 997 cases. *Ann. Surg.* 132: 652, 1950.
8. Edwards, L.W., et al: The surgical treatment of duodenal ulcer by vagotomy and antral resection. *Am. J. Surg.* 105: 352, 1963.
9. Farmer, D.A. and Smithwick, R.H.: Hemigastrectomy combined with the resection of the vagus nerve. *New England J. Med.* 247: 1017, 1952.
10. Fry, W.J. and Thompson, W.W.: Vagotomy and pyloroplasty for duodenal ulcer, *S. Cl. North America* 46: 359, 1966.
11. Weinberg, J.A., et al: Vagotomy and pyloroplasty in the treatment of duodenal ulcer. *Am. J. Surg.* 92: 202, 1956.
12. Palumbo, L.T., et al: Antrectomy with vagectomy for chronic duodenal ulcer, *Surgery* 46: 1005, 1959.
13. Thoroughman, J.D., et al: A review of 504 patients with peptic ulcer treated by hemigastrectomy and vagotomy, *Surg., Gynec. & Obst.* 119: 257, 1964.
14. Scott, H.W., Jr., et al: Vagotomy and antrectomy in surgical treatment of duodenal ulcer disease, *S. Cl. North America* 46: 349, 1966.
15. Stamner, F.A.R. and Williams, J.A.: *Partial Gastrectomy: Complications and metabolic consequences.* Washington, D.C. Butterworth, Inc., 1963.
16. Welch, C.E.: Subtotal gastrectomy for duodenal ulcer, *S. Cl. North America* 46: 339, 1966.

Detection of Asymptomatic Urinary Tract Infection in Girls†

NANCY H. HOLLAND, M.D.*, ROGER JURICHS, AND GIL CLEMONS
Lexington, Kentucky

One in every 100 school girls has unrecognized urinary infection. This study shows that the miniplate culture is a simple office method for early detection of infection and hopefully prevention of chronic pyelonephritis.

THE HIGH prevalence of asymptomatic bacteriuria in school girl populations[1] and the recognition of irreversible renal failure secondary to silent pyelonephritis in adolescent females,[2] makes apparent the need for a simple plan to detect urinary tract infections in girls. Comparison of several methods of collecting specimens and detecting the presence of significant bacteriuria shows that unsophisticated paramedical personnel using the simple miniplate* culture method can screen efficiently for bacteriuria. Five of 397 girls (1.3 per cent) tested had infected urines and were referred to their local physicians or health departments for radiologic examination and therapy.

Methods

Collection. Three sophomore medical students made the contacts and set up the project structure by which 397 girls were screened in three eastern Kentucky counties. Nurses working in a pediatrician's office collected clean voided samples from 76 Headstart (preschool) girls; health aides and high school graduates with no previous medical training collected clean specimens from 306 Headstart girls. During an Appalachian home study mothers, instructed by medical students, collected samples from 15 girls aged 12 years or less. Two hundred and three clean or catheterized urine specimens collected in the University of Kentucky Medical Center clinic and hospital were used also to compare quantitative urine culture methods.

Clean catch urine specimens were obtained by cleansing the labia and vestibule thoroughly with pHisoHex and water, drying with cotton balls and catching a midstream specimen while the thighs were widely spread. Specimens were collected in disposable plastic urine containers and tested immediately or else kept in an ice chest until tested.

Detection of Bacteriuria. Streak plate cultures were made by placing one loop* (0.01 ml) of urine on a trypticase soy agar disposable plastic plate and streaking it thoroughly over the surface. After incubating at 37°C for 48 hours, the colonies were counted and multiplied by 100 to obtain the number of bacteria/ml of urine. Colony counts >10,000/ml of urine were considered positive.[3]

Miniplate cultures were innoculated by the filter paper strip according to directions and were incubated in the same manner as the streak plates. The total number of colonies were counted for comparison with streak plates.

†*Supported in part by a grant from Warner-Chilcott Laboratories, Morris Plains, New Jersey*

**Associate professor of pediatrics at the University of Kentucky School of Medicine, Lexington, Kentucky*

**Testuria, Ayerst Laboratories, New York, N. Y.*

**Jorgansen innoculating loop.*

The Griess test[4], an instant color test, signifies bacterial infection when positive. Griess reagent (acidic sulphanilic acid - alpha naphthalene reagent) added to infected urine turns red immediately if that strain of bacteria converts urinary nitrates to nitrites. Pyuria was defined as five or more WBC/hpf in sediment from 15ml of urine centrifuged for five minutes. Urinary sediment positive for bacteria was graded 1-4+.

Results

Comparison of urine collection methods by medical and nonmedical personnel showed that properly instructed lay personnel performed as efficiently and more economically than nurses. On the initial screen 27 of the 397 specimens collected were positive for bacteriuria. When recalled for a more carefully collected and processed specimen, five of these 27 had significant bacteriuria on the repeat test. Therefore we had 22 false positive screening tests or 6.7 per cent. The incidence of false positive specimens on the initial screen was similar whether collected by nurses (8 per cent), by the previously untrained aides (5 per cent) or by mothers in typical Appalachian homes (7 per cent).

On the initial screen 27 of 397 (7 per cent) of the urines grew out >10,000 col/ml, the criterion for significant bacteriuria. However on repeat testing done within one to two weeks only five children (1.3 per cent) had positive cultures. Results of the streak plate (colony count/ml) was used as a reference for evaluating other methods for detecting bacteriuria.

The miniplate culture technique was found to correlate best with colony counts/ml of urine in diagnosis bacteriuria. Six hundred specimens were cultured in duplicate. Miniplate counts >25 detected all specimens with colony counts >100,000 col/ml plus 1/3 of the counts 10,000-100,000/ml (Table 1). Miniplate counts of ten or more detected another one-third of the specimens with counts between 10,000 and 100,000/ml of urine with only 11 false positive tests in 600 (1.8 per cent). If miniplate counts of four or greater are used as indication of significant bacteriuria 90 per cent of children with colony counts >10,000 will be detected (100 per cent of those >100,000 col/ml and 80 per cent of those 10,000-100,000 col/ml). Incidence of false positive will then be increased to six per cent (36/600).

The Griess test was positive in only two of the five girls with significant bacteriuria again proving that false negatives are common. (Table 2). Two of the other three with negative Griess test grew E. coli and Klebsiella on culture. The specific bacteria was not identified in the third girl who was already on therapy for overt urinary tract infection. The urinary sediment in all five girls with infected urine was positive for bacteria. However bacteria were seen in a third of all sediments and their presence was not a valid criterion for diagnosing urinary tract infections in this study. Microscopic examination of the sediment was usually done after all other tests were completed and the high incidence of positives was

TABLE 1

COMPARISON OF STREAK PLATE (COL/ML) AND MINIPLATE URINE CULTURES*

Colonies per miniplate	Colonies per ml. of Urine: NG	1-1000	1001-10,000	10,001-100,000	>100,000	Total
NG	292	115	18	2	0	427
1-3	11	21	35	5	0	72
4-9	1	5	21	7	0	34
10-25	0	2	7	8	0	17
>25	0	0	2	12	36	50
Total	304	143	83	34	36	600

* 397 specimens were from Headstart study; 213 from children attending the Pediatric Renal Clinic at UKMC.

TABLE 2

CULTURES FROM 5/397 GIRLS WITH INFECTED URINE

Pt	Organism	Col/ml	Mini	Griess	Bacti	WBC/hpf
1)	———	$>10^5$	>25	+	4+	15-20
	*E. coli 0-1	$>10^5$	>25	+	NDt	ND
	NM					
2)	E. coli 0-73	$>10^5$	>25	+	4+	0
	NM					
	E. coli 0-ut	10^4	12	+	ND	ND
	H-2					
3)	———	$>10^5$	>25	—	1+	3-4
	E. coli 0-ut	10^4	5	—	ND	ND
	H-9					
4)	———	$1.6X10^4$	4	—	1+	2-3
	Treated by LMD					
5)		$6X10^4$	16	—	2+	1-3
	Klebsiella	$>10^5$	>25	—	ND	ND
	Type 44					

*Typed at CDC, Atlanta, Ga.
tND — not done.
ut — untypable.

probably an artifact. Pyuria was observed in all five girls with significant bacteriuria but was also observed in 12 girls with counts less than 10,000/ml.

Discussion

Recognition of the large number of persons dying in the United States with chronic renal disease or presenting as candidates for hemodialysis or kidney transplant[5] emphasizes the need for preventive medicine in this area. The large number of asymptomatic infections in school girls[1] suggest that mass screening of preschool and school girls might be a means of reducing the incidence of renal failure due to pyelonephritis in the future. The concept that asymptomatic bacteriuria may result in kidney damage is supported by Kunin's study of school children[1], follow up studies of children with mild symptomatic infection[6,7,8] and by the clinical history of terminal cases of pyelonephritis. In surveying 8,000 girls Kunin found that 122 had asymptomatic infection and that structural changes of the urinary tract could be shown radiologically in over a third of them.[1] Earlier clinical reports point out that minimal clinical findings in children with urinary tract infection may be associated years later with advanced disease[6,7,8].

A review of 1,388 autopsies done at Cincinnati Children's Hospital between 1953 and 1963 showed that 31 children (2.2 per cent) had significant pyelonephritis, that is, pyelonephritis was the cause or a cause of death. Of 13 who died before one year of age, eight were males with anatomical abnormalities, the most common being posterior urethral valves in four of them. Death in the younger age groups may not have been preventable. However six girls in the older age group had no gross anomalies and developed chronic pyelonephritis in a grossly normal urinary tract, a higher percentage than documented in other autopsy series in children[9,10]. Neither those six cases nor three adolescent girls receiving kidney transplants for chronic pyelonephritis at the University of Kentucky Medical Center had a history of urinary tract infection (except a forgotten mild episode in the preschool period) or symptoms suggestive of progressive disease until irreversible damage had occurred. Death or transplantation in these girls may have been prevented by diagnosis during the asymptomatic stage.

The pediatrician or family doctor may take advantage of current techniques and knowlage to eliminate the pool of asymptomatic infection which may result in irreversible disease in later years. Collection of clean urine specimens and quantitative urine cultures may be done by unskilled personnel at minimal cost in the private physician's office. Well child examinations for girls should include a quantitative urine culture.

(continued on page 699)

Estimated Prevalence of Chronic Conditions in Kentucky

David L. Kruegel, Ph.D*
Lexington, Kentucky

National chronic condition prevalence rates are applied to the Kentucky population. An estimated 67 thousand Kentuckians not residing in institutions are limited or impaired so severely that they are unable to carry on their usual major activity.

KNOWLEDGE concerning the local and regional prevalence of chronic conditions is useful for physicians serving on Boards of Health, Health Facilities Councils, Comprehensive Health Planning Councils and other executive or advisory boards. Except for tabulations derived from tuberculosis, venereal and other registers, however, estimates of the local prevalence of chronic conditions are generally unavailable.

This report contains estimates of the prevalence of selected chronic conditions and resulting activity limitation in Kentucky. All estimates were obtained by applying prevalence rates derived from the National Health Interview Survey to the civilian, noninstitutional Kentucky population enumerated in the 1960 census.

Source of Prevalence Rates

The National Health Interview Survey is a program of the National Center for Health Statistics whereby information is continuously obtained from a nationwide sample of households.[1] This survey uses a questionnaire to obtain information pertaining to health, injury, illness and socio-economic characteristics. During a single year, interviews are obtained with approximately 129,500 persons residing in 40,000 households.[2]

There are limitations to the accuracy of medical information obtained through household interviews.[3] However, except for special populations or conditions,[4,5,6] chronic condition prevalence rates based upon medical examination are at present unavailable.

Estimating Procedure

Chronic condition prevalence rates for the United States civilian, noninstitutional population were derived from Tables 1 and 2 of the report *Chronic Conditions and Activity Limitation, United States: July 1961-June 1963.*[2] International Classification of Diseases code numbers for each chronic condition category are reported in the same source. These national prevalence rates were multiplied with the 1960, civilian, noninstitutional Kentucky population of 2,975,641[7] to obtain the estimates shown in Table 1. Estimates for Kentucky Area Development Districts are reported elsewhere.[8]

Results

An estimated 363 thousand civilian Kentuckians not residing in institutions possess one or more chronic conditions or impairments which result in activity limitation. Of these persons, about 67 thousand are limited or impaired so severely that they are unable to carry on their usual major activity of working, keeping house or engaging in school or preschool activities.

The five groups of chronic conditions leading in activity limitation and the estimated number of Kentuckians in each are heart conditions, 58,400; arthritis and rheumatism, 54,000; mental and nervous conditions, 27,900; impairments (except paralysis) of back or spine, 27,200; and impairments (except paralysis and absence) of lower extremities and hips, 22,500. As the severity of the limitation increases, the limiting conditions and their rank order change slightly. But in all activity limitation groups, the two chronic condition categories limiting the largest number

*Lecturer, University of Kentucky Department of Sociology; formerly on the staff of the Kentucky Comprehensive Health Planning Commission

TABLE 1

Estimated Number of Persons Limited in Activity, by Degree of Activity Limitation, for Selected Chronic Conditions Causing Limitation, Kentucky: 1960

Selected chronic conditions	Persons			
	All degrees of activity limitation	Limited, but not in major activity[a]	Limited in amount or kind of major activity[a]	Unable to carry on major activity[a]
All chronic conditions[b]	363,300	100,300	195,800	67,200
Tuberculosis	2,400	c	1,600	800
Malignant neoplasms	3,400	c	1,600	1,800
Benign & unspecified neoplasms	3,900	1,000	2,000	900
Asthma-hayfever	18,200	6,300	8,900	3,000
Diabetes	8,700	1,600	4,400	2,700
Mental & nervous conditions	27,900	7,100	13,800	7,000
Heart conditions	58,400	11,000	31,000	16,400
Hypertension without heart involvement	21,700	5,400	12,600	3,700
Varicose veins	8,600	2,600	4,900	1,100
Hemorrhoids	4,700	1,200	2,700	800
Other conditions of circulatory system	13,700	3,400	6,500	3,800
Chronic sinusitis and bronchitis	9,900	3,100	5,300	1,500
Other conditions of respiratory system	7,500	1,400	3,800	2,300
Peptic ulcers	8,900	2,400	4,700	1,800
Hernias	9,700	1,800	6,000	1,900
Other conditions of digestive system	16,600	3,600	9,000	4,000
Conditions of genito-urinary system	18,100	4,800	9,500	3,800
Arthritis & rheumatism	54,000	11,700	30,900	11,400
Other diseases of muscles, bones, joints	13,100	4,300	7,300	1,500
Visual impairments	20,000	2,900	8,400	8,700
Hearing impairments	7,900	1,600	3,300	3,000
Paralysis (complete or partial)	14,700	2,300	5,300	7,100
Impairments (except paralysis) of back or spine	27,200	7,500	17,100	2,600
Impairments (except paralysis or absence) of upper extremities or shoulders	5,600	1,200	3,600	800
Impairments (except paralysis or absence) of lower extremities and hips	22,500	6,500	11,700	4,200

[a]Major activity refers to the ability to work, keep house, or engage in school or preschool activities.
[b]The number of persons limited in activity due to all chronic conditions is less than the sum of persons limited in activity due to specific chronic conditions since an individual may have two or more chronic conditions.
[c]Figure does not meet standards of reliability or precision.

of persons are heart conditions and arthritis and rheumatism.

Related Report

The state estimates presented in this report are approximately comparable to those in the National Center for Health Statistics report *Synthetic State Estimates of Disability*,[9] except that the federal report does not provide estimates for specific chronic condition categories. Using prevalence rates and population figures provided in the national report, the number of Kentuckians with activity limitation on July 1, 1963, due to all chronic conditions is estimated to be 482 thousand persons compared to the present estimate of 363 thousand persons. The main reason for this difference is that the National Center for Health Statis-

tics estimating procedure takes into consideration state socio-economic levels and recent population trends. The present estimates of activity limitation due to chronic conditions are therefore probably minimum rather than maximum estimates.

Interpretation of Results

The estimates presented in this report are intended only as approximate indicators of activity limitation due to chronic conditions. Small differences in estimated prevalences for specific categories of chronic conditions should be interpreted with caution. It should also be remembered that the national prevalence rates applied to the Kentucky population are based upon information obtained by household interview and not by medical examination and diagnosis.

References

1. U. S. Department of Health, Education, and Welfare, *Origin, Program, and Operation of the U. S. National Health Survey.* Public Health Service Publication No. 1000, Series 1, No. 1: Washington, D. C.: U. S. Government Printing Office, 1963.
2. U. S. Department of Health, Education, and Welfare, *Chronic Conditions and Activity Limitation. United States: July 1961-June 1963.* Public Health Service Publication No. 1000, Series 10, No. 17; Washington, D. C.: U. S. Government Printing Office, 1965.
3. U. S. Department of Health, Education, and Welfare, *Interview Data on Chronic Conditions Compared with Information Derived from Medical Records.* Public Health Service Publication No. 1000, Series 2, No. 23; Washington, D. C.: U. S. Government Printing Office, 1967.
4. U. S. Department of Health, Education, and Welfare, *Cycle I of the Health Examination Survey, Sample and Response, United States, 1960-1962.* Public Health Service Publication No. 1000, Series 11, No. 1; Washington, D. C.: U. S. Government Printing Office, 1964.
5. Commission on Chronic Illness, *Chronic Illness in a Large City.* Chronic Illness in the United States, Vol. IV; Cambridge, Mass.: Harvard University Press, 1957.
6. Commission on Chronic Illness, *Chronic Illness in a Rural Area.* Chronic Illness in the United States, Vol. III; Cambridge, Mass.: Harvard University Press, 1959.
7. U. S. Department of Commerce, *U. S. Census of the Population: 1960.* Kentucky, PC (1)-19C, Table 83; Washington, D. C.: U. S. Government Printing Office, 1962.
8. Kruegel, D. L., *Estimated Chronic Conditions and Activity Limitation for Kentucky Counties and Multi-County Units* (mimeographed).
9. U. S. Department of Health, Education, and Welfare, *Synthetic State Estimates of Disability.* Public Health Service Publication No. 1759; Washington, D. C.: U. S. Government Printing Office, 1968.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Flurandrenolone Tape in the Treatment of Lichen Simplex Chronicus

James W. Bard, M.D.*
Lexington, Kentucky

Eight patients with lichen simplex chronicus responded to treatment with topical corticosteroid, but longer lasting remissions were obtained in 10 patients when surface occlusion was used in addition to the corticosteroid.

LICHEN simplex chronicus (lichen simplex, circumscribed neurodermatitis) is a common dermatosis affecting both men and women from teenage through senescence. At the root of the disease is the capability of the skin to respond to chronic irritation with that form of cutaneous hypertrophy called lichenification. Clinically (FIGURE 1), lichen simplex is characterized as a fairly well marginated patch of thickened skin, usually of a dusky red hue, with exaggeration of normal markings so that the striae form a criss-cross pattern. Scaling, excoriation and acute inflammation are rarely seen, as the lesion is usually dry and slightly squamous. The sites of the predilection are the extremities and posterior scalp and neck. Lichen simplex chronicus is usually classified as a psycho-cutaneous reaction with such contributing factors as localized "itchiness," chronic trauma, nevus flammeus, chronic bacterial infection and chronic contact with irritants.[1]

The histology of lichen simplex chronicus (FIGURE 2) is that of a chronic dermatitis: elongation of the rete ridges, spotty parakeratosis and a mild chronic inflammatory cell infiltrate. In acute lesions spongiosis of the epidermis is present but is often not apparent in older lesions.

In the course of clinical study, flurandrenolone tape was evaluated in several dermatologic disorders, including 10 cases of lichen simplex chronicus with adequate follow-up. Lichen simplex chronicus was chosen as the subject of this report because: (1) the lesions are potentially curable; and (2) the areas of skin involved, being relatively small, are amenable to treatment with the medicated tape.

Flurandrenolone tape is a transparent plastic tape containing 4 mcgs. of flurandrenolone per square cm. The tape as supplied for clinical investigation was three inches wide and had a protective paper liner.* Patients were instructed to cleanse the lesion, then cut the tape to the proper size, peel off the liner and apply the tape directly to the lesion. The tape was to be changed every 24 hours.

In the treatment of lichen simplex chronicus it must be kept in mind that without continued irritation, even that produced by a very modest amount of rubbing, the lesion will disappear. For the great majority of patients this is easier said than done, and some adjuvant therapy is needed to break the itch-scratch cycle. All patients were instructed to cease any irritation, either of a mechanical type (scratching) or the application of topical

*Section of dermatology, Lexington Clinic, Lexington, Kentucky

*Flurandrenolone tape furnished by E. Linn Jones, M.D., Medical Research Division, Eli Lilly Research Laboratories, Indianapolis, Indiana.



FIGURE 1. Lichen simplex chronicus on the volar wrist showing lichenification.

home remedies, many of which have irritative properties.

Method

Eighteen patients are included in this study; 10 used flurandrenolone tape and eight used a topical corticosteroid preparation without occlusion. Although the topical corticosteroid group had a similar range of age and of duration and clinical appearance of the lesions, they are not identical with the test group. The most significant difference was that 60 per cent of the tape group had previously used topical corticosteroid alone and had found it ineffective. The clinical data are collected in the table.

Results

In both groups the average age was 46 and the average duration of the lesions prior to therapy was 13 months. There were more women in the group treated with topical corticosteroid (five of eight) compared with the group treated with tape (four of 10). Response to therapy was graded as excellent, meaning complete involution of the lesion; good, meaning marked improvement; and fair, meaning partial improvement. All patients experienced some benefit from their treatment. The significant finding of this study was that seven of the 10 treated with tape (70 per cent) showed complete involution of their lesions with no recurrence during follow-up (average of 12 months), whereas only two of eight (25 per cent) showed a similar response to topical corticosteroid without occlusion and after follow-up which averaged 14 months.

Comment

It is well known that the treatment of localized lesions by topical corticosteroids is often enhanced by the use of an occlusive dressing. This is thought to result from increased absorption of the medication, maceration and protection of the lesion from mechanical and chemical irritation. Usually occlusive therapy is achieved by liberally inuncting the skin with a corticosteroid cream or ointment and then covering the affected area with a piece of plastic taped down at the edges.

The advantages of the use of the topical corticosteroid incorporated into a plastic tape base are listed by Goldman, et al. as: (1) ease of application; (2) exact control of dosage; (3) inconspicuous appearance through the occlusive dressing; (4) better adherence to the skin; and (5) more effective occlusion.[2] The patients in this study found flurandrenolone tape to be an attractive and effective form of therapy. Three of the 10 patients experienced minor side effects which consisted of burning or irritation under the tape but did not necessitate discontinuing therapy.



FIGURE 2. Histology of lichen simplex chronicus.

TABLE 1

TREATMENT OF LICHEN SIMPLEX CHRONICUS

Case	Age	Sex	Previous Topical Steroid	Duration Prior to Therapy	Results of Therapy	Length of Followup	Post Treatment Relapse
			Treated with Topical Corticosteroid Without Occlusion				
1	78	F	No	24 mo.	Excellent	28 mo.	Yes
2	14	F	No	24 mo.	Excellent	19 mo.	Yes
3	37	F	No	2 mo.	Excellent	8 mo.	No
4	33	M	No	24 mo.	Excellent	11 mo.	No
5	74	M	No	5 mo.	Foir	5 mo.	Yes
6	56	M	No	12 mo.	Good	8 mo.	Yes
7	51	F	No	Unknown	Fair	11 mo.	Yes
8	24	F	No	1 mo.	Fair	23 mo.	Yes
			Treated with Flurandrenolone Tape				
9	70	F	No	24 mo.	Excellent	7 mo.	No
10	64	M	Yes	2 mo.	Good	15 mo.	Yes
11	37	F	Yes	24 mo.	Good	5 mo.	No
12	16	M	No	12 mo.	Excellent	11 mo.	No
13	11	M	Yes	24 mo.	Fair	11 mo.	Yes
14	62	F	Yes	11 mo.	Excellent	14 mo.	No
15	39	M	Yes	6 mo.	Excellent	12 mo.	No
16	61	M	No	6 mo.	Excellent	12 mo.	No
17	52	F	Yes	12 mo.	Excellent	16 mo.	Yes
18	44	M	No	24 mo.	Excellent	16 mo.	No

Summary

Eighteen patients with lichen simplex chronicus were observed for results of therapy. All showed some benefit, ranging from complete clearing to partial improvement. Six who had been unsuccessfully treated with topical corticosteroid without occlusion were given flurandrenolone tape, as well as four others who had had no previous therapy. Of the 10 patients using the tape, lasting remissions were obtained in 70 per cent, whereas in a similar group using topical corticosteroid without occlusion such remissions were obtained in 25 per cent. Occlusive corticosteroid therapy seems to be a superior form of treatment in lichen simplex chronicus.

References

1. Pillsbury, D.M., Shelley, W.B., and Kligman, A.M.: *Dermatology*, W. B. Saunders Co., 1956, pp. 410-412.
2. Goldman, L. Igelman, J.M. and Kitzmiller, K. W.: Clinical Investigative Studies with Fluradenolone Tape, *Cutis, 3,* (4) :367-371, April, 1967.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time...
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband...
and for herself as well...
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodial diacetate 1 mg., mestranal 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembalic disorders, cerebral apaplexy or a past history of these conditians, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estragen-dependent neaplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch far the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmanary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral cantraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiapathic" thrombaembolism, statisticol evaluation indicated that the differences observed between users and non-users were highly significant. The canclusions reached in the studies are summarized in the table below:

Camparisan af Martality and Haspitalization Rates Due to Thromboembalic Disease in Users and Non-Users af Oral Cantraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users af Oral Cantraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No camparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to wamen in other cauntries in which the incidences af spantaneously occurring thromboembolic disease may differ.

Discantinue medicatian pending examinatian if there is sudden partial or complete loss of vision, or sudden onset of praptosis, diplapia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demanstrated, it is recammended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the cantraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect an the nursing infant cannat be determined at this time.

Precautions—Pretreatment physical examination shauld include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endacrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for twa months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctianal causes. Adequate diagnostic measures are indicated in undiagnased vaginal bleeding.

Carefully observe patients with a history af psychic depressian and discantinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine functian awaits further study.

A decrease in glucose tolerance has accurred in a significant percentage af patients on oral contraceptives. The mechanism of this decrease is abscure. For this reason, diabetic patients should be abserved carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal clasure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient canstitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following seriaus adverse reactians: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an associatian, such a relationship has been neither canfirmed nar refuted for the following serious adverse reactians: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spatting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppressian of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

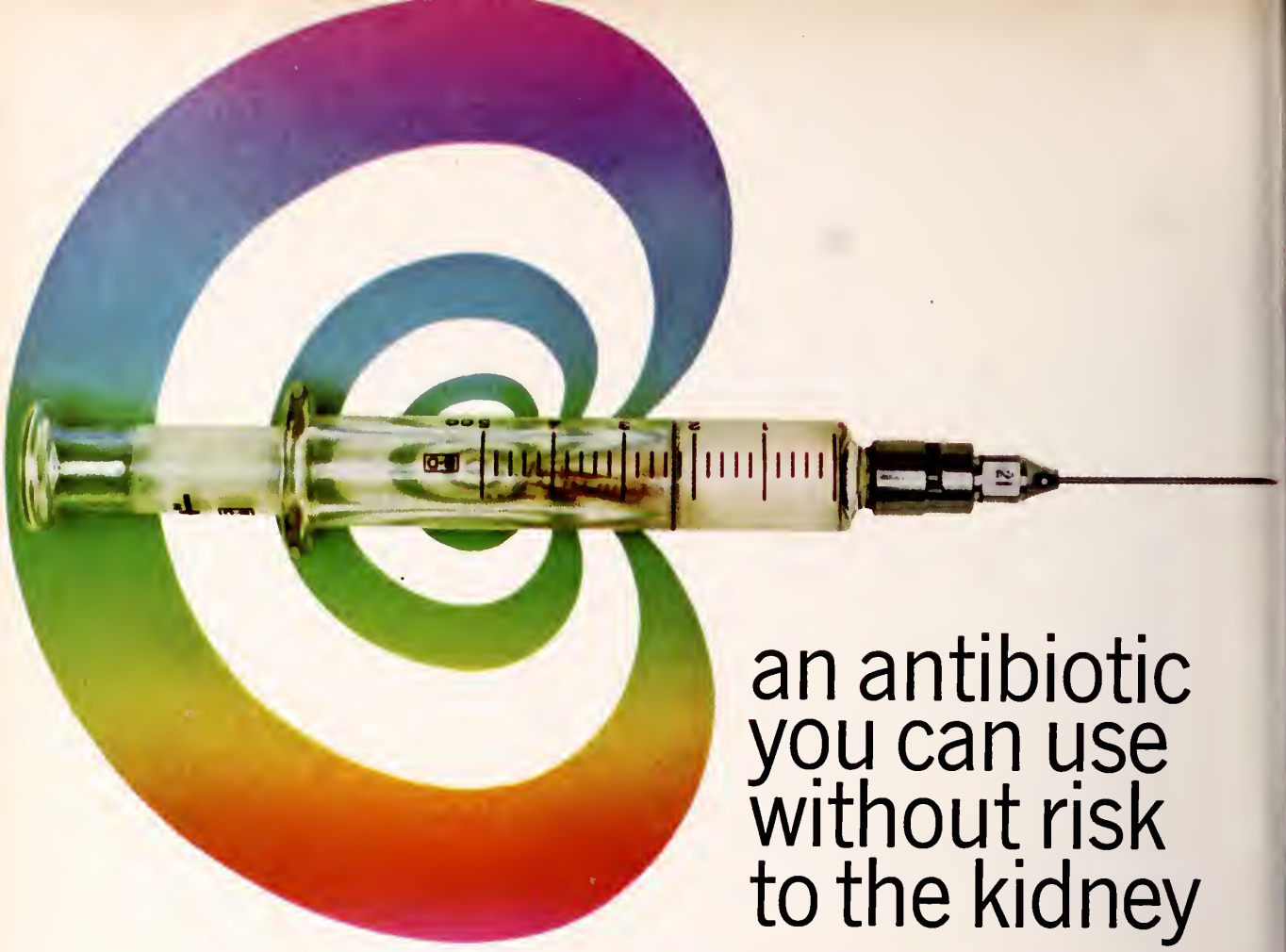
Although the following adverse reactians have been reported in users of oral contraceptives, an associatian has been neither confirmed nor refuted: anavulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemarrhagic eruption, itching. The following labaratory results may be altered by oral contraceptives: hepatic functian: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began
G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE



an antibiotic you can use without risk to the kidney

Polycillin-N

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

PRESCRIBING INFORMATION. 11—1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

A.H.F.S. Category 8:12.16

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



symptoms of mixed anxiety-depression are rarely clear-cut.
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

SPECIAL ARTICLES

The Clinical Associate: Rationale for Training A New Health Professional

RALPH W. EICHENBERGER, M.D.*, JOSEPH HAMBURG, M.D.**, ROBERT W. EWER, M.D.*** THOMAS G. KOTHEIMER, JR., M.D.****

A new health professional is proposed who would be an assistant to the physician in a more intimate and responsible clinical role than any of his present "informal" assistants.

Background

FOR SOME time it has been apparent to many both within and outside the medical profession that an unfavorable balance was developing between health care demands (needs and wants) and the supply of health professionals. Among the many solutions proposed for meeting these demands is the restructuring of our health delivery methods in order to utilize the knowledge and skills of our highly educated professionals in the most efficient and meaningful manner possible while maintaining a high quality of care of the patient.

Recent years have seen a growth of the team concept through the development, not only of a host of professionals allied with the physician, but a hierarchical continuum of persons within the professions contributing their various degrees of competencies to total patient care. In addition, a genuine need has become apparent to create a new kind of health professional who will provide aid to the physician at the point of critical function, the primary contact with the patient in diagnosis and treatment.

The idea of an assistant to the physician is not new. Practically every physician in practice can identify in his own office someone who is his "right hand man", or more likely, his "girl Friday". Many practitioners will testify they could not get along without such a person.

What is new in some of the recent proposals concerning a physician's assistant is the institutionalization of this *position* into one of professional status. But the creation of the Physician's Assistant is not at all an undisputed fact. There have been numerous serious discussions of the whole question.[1-4]

The arguments for and against these proposals in the literature need not be restated here. We would like to present some of the considerations which have led us toward the development of a proposal to establish and train a new health professional, the Clinical Associate.

The Informal Assistant

The essential nature of the present "informal assistant" is as varied as the individual physicians who have trained and employed them. But there are some identifiable factors that determine the function she will perform.

The informal assistant is usually selected by the physician or selects herself out of the office staff by certain characteristics of personality and a special aptitude. There follows a shorter or longer—but usually a continuous on-the-job training for a role as assistant to the physician. The nature of the informal training is dictated by the physician's available time and the trainee's potential for learning.

The extent of "medical" or "clinical" duties delegated to the informal assistant is dependent upon other variables such as the type and location of the practice, and the characteristics of the clientele served. However, the physician cannot delegate to anyone the ultimate responsibility for his patient, nor should it be otherwise. In this respect the physician is in a unique position. Someone must have the ultimate responsibility in health care, and for all his limitations no one else in the ranks of health professionals is better qualified to deal with the total individual in illness (we need not say health) than the physician.

Some arguments have been advanced which suggest that the formal establishment of the Physician's Assistant role which mean abdication by the physician of his ultimate authority, his final responsibility. We believe the following proposal for the Clinical Associate leaves these prerogatives intact while ful-

* *Chairman, Department of Community Health, University of Kentucky Medical Center*

** *Dean, School of Allied Health Professions, University of Kentucky Medical Center*

*** *Assistant professor of medicine, University of Texas Medical Branch*

**** *Clinical Associate, University of Texas Medical Branch*

filling the expressed need of many practicing physicians for a special kind of aid.

A little-known experiment conducted by the University of Kentucky College of Medicine in 1966-68 gave impetus to the concept of the Clinical Associate. At that time a young man of average intelligence, having a background of one year of college and some hospital training in inhalation therapy was enrolled in a two year program. One year was spent in the University and one year with an internist in a group practice for his preceptorship. Although the curriculum was not ideally constructed, we proceeded to see what could be accomplished in the training and use of such a Clinical Associate. His quality of performance exceeded our expectations, and we were convinced that this preliminary experiment was worthy of further, more careful pursuit.

The basic concept of the Clinical Associate is that he be associated with a duly qualified and licensed physician; that he be a true "associate" of the physician; and that he function only as an agent of the physician in a clearly delineated set of activities. We are not proposing to create a watered-down physician. Nor are we suggesting a substitute or replacement for the primary physician. The crucial point of this definition is its focus upon ancillary *activities* rather than upon the judgments and decision-making required of a fully trained physician.

To begin the delineation is to ask the question, what does the physician *do* that may be done by the Clinical Associate? The following table attempts to reduce the activities of these two professionals to a basic formula as it might pertain in primary and continuing health care.

The Physician-Associate-Patient Relationship

1. The physician professes that the health of human beings (the alleviation of suffering, the prolongation of life, and the improvement of the quality of life to the best of his abilities) is his primary concern. This for the physician is a moral and ethical commitment. He recognizes that this is not his concern nor commitment solely.

The Clinical Associate and every other person aspiring to a professional career in health must also profess this commitment as a requisite to entering the field. This is not new. We expect it now as a moral and ethical principle. Most of the allied health professional organizations require this for certification. It is this commitment that identifies a health professional.

2. The physician enters into an implied contractual relationship with a patient, that however difficult to define, is a unique one. It is this relationship toward the whole person with regard to his health which is not the same for any other health professional.

This is the elusive, though not illusory, physician-patient relationship. In our society it is also a legal responsibility with certain invested responsibilities and authorization unique to the physician.

The Clinical Associate as here proposed will *never* enter into this contractual relationship, implied or overt, *vis-a-vis* a patient. In terms of activities, this is the characteristic which distinguishes the Clinical Associate from the physician. As an agent there may be established an associate-physician-patient relationship or a physician-associate-patient relationship (depending on how you construct your concept) but never an associate-patient relationship.

3. The physician establishes communication with a patient in order to investigate his state of health. The Clinical Associate will establish communication with a patient in such a way that there is no implied contractual "physician"-patient relationship, but rather assertedly as an associate to a physician who does certify this contractual relationship.

The function of communication is an essential one to the concept of the Clinical Associate. He must be qualified and authorized to perform this function which traditionally has been the responsibility of the physician. Given the responsibility for developing the history and physical examination the Clinical Associate becomes a true associate and an extension of the physician.

Because of the adequacy of the training program of the Clinical Associate, the physician will be able to certify his reliability to perform such investigation. As for patient acceptance of this, the physician is the only party to the physician-patient contract able to make a valid judgment of the Associate's competence. In the University of Kentucky experiment mentioned previously, the physician's certifi-

TABLE I

PHYSICIAN	CLINICAL ASSOCIATE
1. Professes primary concern for the health of people.	1. Yes, as professional in his own right.
2. Enters into a contractual relationship with patients.	2. Never
3. Establishes communication in order to determine the health state of the patient. a) elicits a history b) performs an examination c) makes a tentative diagnosis	3. Yes, as an agent of physician. a) yes, as an agent b) yes, as an agent c) makes at least a preliminary judgement about the diagnosis
4. May prescribe further investigation. a) diagnostic tests b) other professional consultation	4. Yes, with certain limitations. a) as an agent and under certain conditions b) always with his physician associate
5. May administer or prescribe therapy.	5. Yes, under certain limitations and always as an agent of the physician

cation was the crucial factor in patient acceptance of this new professional.

The question will be raised, "Can anyone less than a physician make a diagnosis?" It is proposed that the Clinical Associate be authorized to make a judgment about the diagnosis. The physician, after performing the history and examination, reflexly makes a tentative diagnosis in order to proceed further. It may not be the final diagnosis, for that may require extensive cogitation, bringing to bear upon the problem all the background of basic biological sciences and diagnostic acumen in his clinical experience.

Essentially what is being proposed for the Clinical Associate is that he be an extension not only of the physician's senses but to a degree of his "reflex arc" as well. This is not independent action, so conceived. The physician will continuously assure himself that his Associate is capable of making limited judgments about diagnoses and that he may make those judgments in his, the physician's, name in order to proceed further.

Health problems about which the Clinical Associate may make preliminary judgments will be spelled out by each physician for his Associate.

The general rules will be governed by what his training should prepare him to do; the specific terms will be what the physician assures himself his Associate *can* do in the way of preliminary judgments regarding diagnoses.

4. The subsequent step, performing or prescribing further investigations, follows from the previous one. The Clinical Associate should be able to perform or prescribe certain diagnostic tests as spelled out in specific terms by his physician (and possibly by clinic or hospital policies governing this area).

Whereas the physician in his judgment may elect to call in other professional consultants, the Clinical Associate will *always* call for consultation but only with his own physician (or in certain circumstances perhaps his designated alternate).

The exact manner and circumstances of the consultation again will need to be defined in detail by the physician for his Associate. General guidelines or rules can be developed. Under certain circumstances, for example, such consultation need not demand the *physical presence* of the physician with the Associate and/or the patient. It may be carried out by telephone, it may be in writing, it may be by TV or other electronic communication. Under certain circumstances it may not be *immediate* consultation. What is asserted is that there must be *eventual* consultation in every instance for ultimate disposition of the case, and for legal purposes ought to be subscribed to in writing (signature, at least) by the physician.

5. Of all the questions that will be raised over the proposal of this new professional, it is the last point under the above tabulated functions that will draw the greatest objections. It is certainly in the act of prescribing treatment that the physician's prerogative stands out.

Nevertheless, it is proposed that, in *certain confrontations* with a patient, after the Clinical Associate has proceeded through establishing communication with the patient, investigating his health status and arriving at a preliminary judgment about the diagnosis, he be authorized to administer and prescribe therapy, but only and always as the agent of the physician.

In our society the physician is legally responsible for his actions and those of his agents. We are not proposing to change that. The criteria for the Associate taking independent action even as an agent needs to be spelled out most carefully. Specifically, certain prescriptions or treatments would be prohibited; some might be conditional; others might be permitted; all would ultimately be subscribed to in writing by the physician (signature, at least).

How carefully should the job description of the Clinical Associate be spelled out? How much of the job skills which the Associate will learn should be certified? How much of his activities should be legalized? These are questions which require the experimentation inherent in this proposal. The answers to these questions will require the close collaboration of training institutions and practicing physicians.

Training Program

Exact curricular content has yet to be established for the training of the Clinical Associate. The length of time and the courses of study vary with differing concepts as to the role and duties of the physician's assistant. Until such time as the outputs from ongoing programs can be properly evaluated, decisions as to the above mentioned variables must remain conjectural. Based upon our very limited experience we have proposed a 24-month program recognizing full well that adjustments may have to be made as we develop additional experience.

If the activities of the physician and the Clinical Associate can be identified as in the table, and if it is accepted that the primary objective for the Clinical Associate is to prepare him to deal with the *how* of medical service, then the curriculum should be based on teaching the *skills* of the physician and certain other health professionals. It would seem reasonable, therefore, to develop the basic curriculum within a utilitarian model, teaching only what the Clinical Associate will be expected to use.

The first year of the program would provide a common core of studies in the basic sciences as well as medical terminology, medical ethics, history-taking and physical diagnosis, and so on. In addition, there would be instruction and practice in the performance of selected laboratory examinations and in the use of certain diagnostic apparatus such as X-ray, EKG, audiometer, tonometer, etc. Emphasis would be on fundamental principles in all the courses. Laboratory and clinical experiences would stress the practical aspects.

As conceived, the first year of the basic course would focus upon preparing the generalist, a Clinical Associate, who could do some of the things any physician does whether general practitioner, internist, pediatrician, surgeon, orthopedist or any of the super-specialists. The last year would permit either

more intensive generalization or specialization depending on the desires and interests of the student. A period of selected preceptorship experience under controlled conditions would be an integral part of the last year.

Because of the generalist nature of the basic course, lateral mobility within the medical profession would be possible. However, it seems most prudent, in view of the role of the Clinical Associate as we conceive of it and the nature of medical practice as it is, to encourage the student to seek carefully a niche, choose a physician with whom to associate, and become established. There would be little satisfaction for the dilettante in this profession and, by definition, no place for the entrepreneur. On the other hand, there would be ample opportunity for his acquiring additional knowledge and skills, and for continually increasing his responsibilities and privileges under the certification of his physician associate.

The Clinical Associate as here proposed need not have a legalized list of activities. Rather, he will be authorized to do only what his physician associate will subscribe to his doing.[5]

At the completion of the training period he should be prepared to assume varying responsibilities in the following areas and could be so certified:

- the fact-finding tasks of the history and physical examination.
- performing certain diagnostic precedures, EKG, pulmonary function tests, audio and visual tests.
- monitoring the health status of the chronically ill patient for the physician by complementary visits to the hospital, nursing facility, or home.
- performing certain tasks such as catheter care, taking body fluid samples for analysis, starting intravenous medications, inhalation therapy, etc.
- performing certain minor surgical procedures, incision and drainage, suturing, assisting his physician in major surgical procedures, etc.

It is expected his expertise and capacity for judgment will develop and expand through his association with the physician and be further augmented by required formal continuing education experiences. To these competencies the physician will be willing to certify by subscription, by continued employment and by recommendation to another physician if his Associate should desire to change employer.

Selection of Candidates

Because our concept of the Clinical Associate allies him to the physician in a close and, hopefully, lengthy association we believe selection criteria to be of primary importance. We are proposing that, in the beginning at least, physicians in our state, practicing in a variety of delivery systems, who have already expressed a desire to employ such a Clinical Associate, might submit candidates.

If they meet the entrance requirements and successfully complete their training, they might return to the sponsoring physician for preceptorship or internship, with the possibility of further association in employment. We see this as possibly providing a workable solution to several problems of the program: recruitment of desirable candidates, vital involvement of the practicing physicians in the training and testing of this new professional and assurance of an employment market for the graduates from the very beginning.

We believe the development of a healthy professional ego as well as a strong professional ethic will be crucial to the successful establishment of the Clinical Associate as a profession. Therefore proper motivation and single-minded commitment to the profession as here proposed are prime requisites for candidates.

Summary

A program is proposed for training a new health professional, the Clinical Associate. It is the professional status to which this position is elevated and the expanded clinical function that would be assumed that make this assistant to the physician different from any present "informal" assistant.

The pilot program as proposed would attempt to test the Clinical Associate concept as to the feasibility of a foreshortened training program, and the acceptance and effective utilization of the graduate.

Specific variables to be developed and tested include:

-candidate selection criteria.

-the recruitment of candidates through practicing physicians.

-curriculum content and teaching methods based on a utilitarian model.

-continuing evaluation of the developing professional in the training period.

-a preceptorship program outside the educational institution in a variety of health care delivery systems and under a variety of medical subspecialties.

-a continuing education, evaluation and certification program for the graduate.

The proposal does not seek to create a middle level medical worker who could or would function as an independent practitioner. For this reason legalization of the role is not proposed. Rather this new professional is conceived of as a close associate to a qualified and licensed physician. His training program would prepare him and certify his competency to function in a broad but ancillary role to the physician. His authorization to function at all would be subscribed to by his physician associate.

The motive for creating this new professional is not to bring second rate health care to any segment of our population. It is not to establish any type of triage health service. It is not proposed simply as a solution for keeping in the ranks of health professionals the large numbers of returning service personnel. The motive for creating this Clinical Associate is to provide the type of trained assistant whom the physician needs to practice effectively if he is to meet the increasing demands upon him in the future.

(continued on page 696)

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

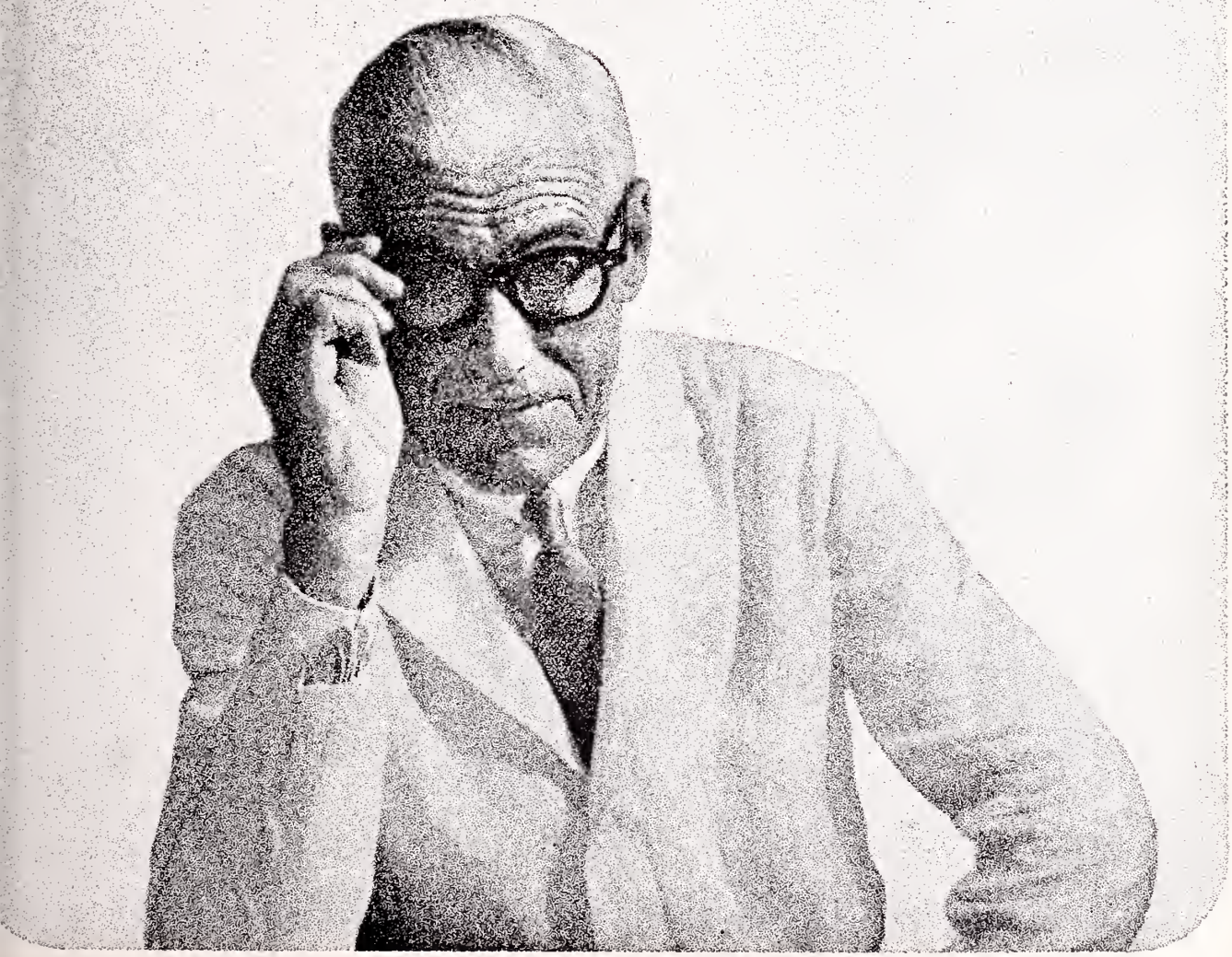
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



when it's late in life and anxiety and depression coexist...

initial therapy

Triavil® 4-10

Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride

maintenance therapy

Triavil® 2-10

Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

appropriate therapy in an appropriate dosage





During the years of declining strength and increasing infirmity, many patients are more sensitive to both the desired response and the unwanted effects of some drugs. That's when low-dosage therapy is needed. And that's when TRIAVIL 4-10, as initial therapy, and TRIAVIL 2-10, for maintenance, can prove particularly useful.

Starting with TRIAVIL 4-10 should help minimize possible dose-related side effects in the geriatric patient with coexisting anxiety and depression. And, subsequently, TRIAVIL 2-10 can increase flexibility in adjusting maintenance dosage.

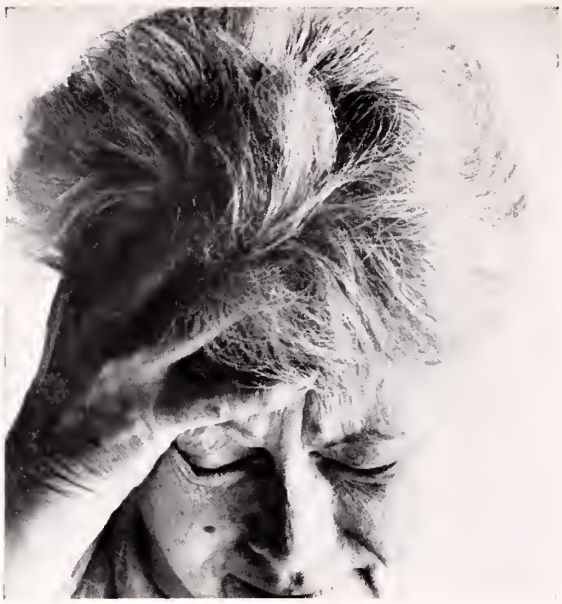
Activities made hazardous by diminished alertness should be avoided. You will want to inform your patients that the effects of alcohol may be potentiated. Because of the potentiation of other drug effects possible with MAO inhibitors, such agents should not be given concomitantly with TRIAVIL. However, therapy with TRIAVIL can be initiated cautiously two weeks or more after withdrawal of the MAOI drugs. And, until significant remission is observed, close supervision of any seriously depressed patient is, of course, essential to guard against possible suicide. The drug is contraindicated in glaucoma, in patients expected to experience problems of urinary retention, in drug-induced CNS depression, and in bone marrow depression.

TRIAVIL 4-10 & 2-10—tranquilizer-antidepressant therapy especially appropriate for the elderly patient so often intolerant to medication in high dosages.

TRIAVIL®
containing perphenazine and amitriptyline HCl
TRANQUILIZER-ANTIDEPRESSANT

for moderate to severe anxiety with coexisting depression

For additional prescribing information, please see following page.



TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

TRIAVIL 4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.
TRIAVIL 2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 2-10: For use in adjusting maintenance dosage. Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

for moderate to severe anxiety with coexisting depression

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory reponse.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone. **Perphenazine:** Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe, acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides. **Amitriptyline:** Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Before prescribing or administering, read product circular with package or available on request.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co. INC., West Point Pa 19486
where today's theory is tomorrow's therapy

vacation in
a vial:
the spasm
reactors
in your practice
deserve



"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

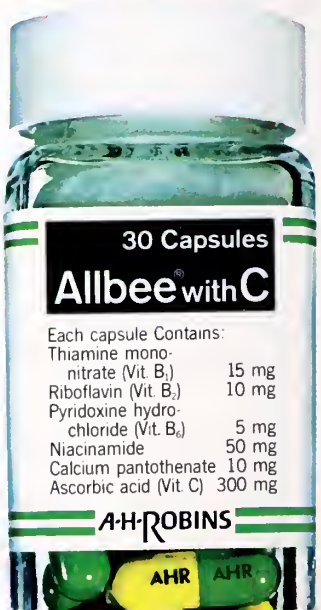
A·H·ROBINS

Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A.H. Robins Company, Richmond, Va. 23220

–The lowest priced tetracycline–nystatin combination available–



HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully intregated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201

EDITORIALS

Deans, Then and Now

DURING the past 50 years, the University of Louisville School of Medicine has had a succession of exceptionally fine physicians in the position of Dean. Henry Enos Tuley, M.D., a distinguished obstetrician and member of the faculty, assumed this post in 1914 and continued until 1923 when illness caused him to be away most of the year. Those of us who were in school during his administration remember him as a remarkably fine gentleman whose close relations with students, and sympathy with their problems, was one of his chief characteristics. This period, carrying through World War I and into the beginning of a new era in medical education, was one of great difficulty for any dean. It was during that time that the school was threatened with loss of accreditation, causing considerable anxiety among the students. Doctor Tuley is remembered as the principal stabilizing factor in these years of unrest and uncertainty.

During Doctor Tuley's illness Stuart Graves, M.D., professor of pathology, assumed the position of acting dean and served as dean during the years 1923 through 1928 when he assumed a similar position at the University of Alabama. Doctor Graves was a man of vision and unlimited energy. He brought to the faculty many young men of fine training and capabilities who have meant much to the school and to the private practice of medicine in this area until the present date.

In 1928 and 1929 the office was vacant and the affairs of the school were conducted by an executive committee selected from the faculty. In 1929 John Walker Moore, M.D., disengaged himself from private practice in internal medicine to assume the office of dean which he continued until illness compelled his retirement in 1949. This long period covered perhaps the most difficult years that the school has experienced during the last half century: the prolonged depression, disruptions occasioned by World War II and the years of readjustment immediately after. Doctor Moore is remembered with the deepest appreciation and love by nearly 2,000 of his former students who are scattered over the world, and whose contributions to modern medicine have been significant. Every former student of his entertains the hope and belief that he has just a little bit of John Walker in him yet.

The committee for the selection of his successor used remarkable wisdom in choosing his protege and associate in cardiac research, J. Murray Kinsman, M.D., an internist and cardiologist of distinction. One of the difficult adjustments of this period came with establishment of the new Medical School at the University of Kentucky in Lexington. Doctor Kinsman is very largely responsible for the fine relationship and close cooperation between these schools during the period of its organization and its operation for the past 10 years. Revision of the curriculum was a very significant accomplishment of his administration. Following his retirement he served for two and one half years as vice president of the University of Louisville relating to the affairs of the Medical Center. In 1966 he re-entered the private practice of internal medicine-cardiology in Louisville.

Donn Smith, M.D., assumed the deanship in 1963 and continued until the end of the school year 1969 when his retirement from that position became effective. The responsibilities of

his office have been exceedingly demanding and he has discharged them with great credit to the University, the Medical School and to himself. He carried to its conclusion the relocation of the school to its new site and the building of a 28 million dollar plant to house the Medical and Dental Schools and library. This expansion has been the most ambitious undertaking for the school during the past 50 years.

There is always a certain amount of unrest in moving from one school to another by the faculty members, and periodically every school undergoes some sort of a minor upheaval. This occurred at the University of Louisville School of Medicine during the past two years; it brought a period of pressure and some public criticism for Dean Smith. It is to his credit to know that replacements on, and strengthening of the faculty have occurred without interruption. The present faculty is perhaps better than it has ever been in the school's long history.

For a man whose entire experience has been in the preclinical sciences, teaching, and research, or in school administration, Doctor Smith has manifested an exceptionally fine understanding of and rapport with the private practitioners of medicine in this area. He early announced his credo that the medical education of Kentucky youth, primarily, and close cooperation with the physicians of Kentucky, would be his prime objectives. This he has carried through with remarkable consistency.

He has been an active member and participant in the Jefferson County Medical Society and the Kentucky Medical Association. He has accepted appointment on committees in both of these organizations, and has served with regularity and effectiveness. He has been a member of the Selective Service Committee and has never hesitated to release promising young members of his faculty when they were called to active military duty. There has never been a better or more cooperative relationship between the school and the private practitioners of medicine in this area than during Doctor Smith's administration. This is evidenced by the Jefferson County Medical Society devoting its program of June 1969 to an appreciation for Doctor Smith and his work in our community.

The University of Louisville School of Medicine stands at the very beginning of a new period of growth and wider influence. Its continued vitality and service during the past 50 years has been due in very large part to the very distinguished gentlemen mentioned in this sketch. We of Louisville and Kentucky who have long been interested in the school regret that the present dean, who has made such a significant contribution during the past six years, has not seen fit to remain to direct it into its promising future.

SAM A. OVERSTREET, M.D.

1969 KMA Annual Meeting

September 23-25

Convention Center

Louisville



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories



the inside story of a new antacid formulation...

with consistent buffering you can measure

consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antocid studies, doto on file, Worner-Chilcott Loborotories Divisian.

introducing new

GELUSIL®-M

eoch 5 ml. teaspaanful cantains:
500 mg. magnesium trisilicate, 250 mg. aluminum hydroxide (Warner-Chilcott), 200 mg. magnesium hydroxide
U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

† Avoids constipation.

See next page far prescribing informatian ►

GELUSIL–one name to remember...and a dosage form for every patient



Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-93-4C

ORGANIZATION SECTION

Crackerbarrel Session, Luncheon Featured At Annual Meeting

A Crackerbarrel Session and an address by the editor of the *Indianapolis News* at the President's Luncheon will highlight the program planned for the KMA Annual Meeting September 23-25 in Louisville.

Twenty timely medical topics will be discussed in a new Crackerbarrel Session on Wednesday afternoon, September 24. Guest physicians will come to the state from all parts of the country to participate in the scientific discussions and the sixteen specialty group meetings.

The scientific program will feature such themes as "Cancer," "Drugs," "Atherosclerosis," "Transplants," "Obesity," and "School Health."

M. Stanton Evans of the *Indianapolis News* will talk to physicians and their wives at the President's Luncheon September 24 in the Flag Room of the Kentucky Hotel. His talk will be "The Future of Freedom." KMA's three top awards will also be presented at that time.

A wide variety of technical and scientific exhibits will be on display during the three-day session at Convention Center for the benefit of members and guests.

Other features of the Annual Meeting will include two sessions of the KMA House of Delegates, an Orientation program for new KMA members, the Annual Convention of the Women's Auxiliary, the annual KEMPAC seminar, and alumni reunions of the University of Louisville School of Medicine.

KMA President Henry B. Asman, M.D., urges all Kentucky physicians to take advantage of this opportunity to acquire the latest information on the rapid changes in medicine's progress by attending the 1969 Annual Meeting.

Reception Planned During Mtg., Given By KMA and Auxiliary

For the second year, the Kentucky Medical Association and the Woman's Auxiliary to KMA are planning a reception during the Annual Meeting. You are extended a most cordial invitation to attend the reception from 5:30 to 7:15 p.m., Tuesday, September 23, in the Mirror Room (just off the lobby) of the Kentucky Hotel.

The KMA and Auxiliary hope you will find this to be an opportune time since there are other meetings scheduled later in the evening.

At the reception you will have the opportunity to greet the president-elect of KMA, Walter L. Cawood, M.D., Ashland, and the president-elect of the Auxiliary, Mrs. Hoyt D. Gardner, Louisville, and to meet some of our distinguished guests and your friends from throughout the state.

KPA Names Glasgow Pharmacist President-Elect at July Mtg.

Joe D. Taylor, R. Ph., Glasgow, was chosen as president-elect of the Kentucky Pharmaceutical Association at its 92nd annual convention at Stouffer's Louisville Inn. Joseph T. Elmes, R.Ph., Louisville, was installed as president.



Mr. Taylor

Other KPA officers for 1969-70 include David D. Dubrock, R. Ph., Arlington, second vice-president; Norman C. Horn, R.Ph., Hopkinsville, third vice-president; Leo J. Wagner, R.Ph., secretary; and Maxwell H. Schulten, R.Ph., treasurer. Wagner and Schulten are both from Louisville.

Taylor, a 1957 graduate of the University of Kentucky College of Pharmacy, is a past president and secretary of the Fourth District Pharmaceutical Association. For the past three years he has served on the Board of Directors of the Kentucky Pharmaceutical Association.

AMA Delegates At Annual Session Consider 196 Business Items

Delegates to the 118th Annual Convention of the American Medical Association held in New York July 13-17 set an all-time record in acting on 196 items of business.

Business presented to the House included 59 reports from the Board of Trustees, the Executive Vice President, and standing and special committees. Of the other 137 resolutions, four were memorials and one a commendation of President Wilbur.

Thirty reports were adopted by the House, one adopted and referred, five amended and adopted, 17 approved, and two accepted for information. Four required no House action.

Of the 137 resolutions, 17 were adopted, 28 were amended and adopted or a substitute was adopted, 30 were referred, with or without amendment, 44 were combined with one or more other resolutions before

action was taken, one was partially adopted and partially referred, 15 were rejected and two were withdrawn.

In addition to business actions, the delegates to the House, in session 15 hours and 40 minutes, heard a speech by the Vice President of the United States, Spiro T. Agnew; listend to an informal address by the newly appointed Secretary of Health, Education and Welfare for Health and Scientific Affairs, Roger O. Egeberg; heard a final report of President Dwight L. Wilbur; presented a special award to the medical staff of NASA's Manned Spacecraft Center in Houston; and listened to reports from AMPAC, AMA-ERF and SAMA.

Walter C. Bornemeier, M.D., Illinois, was elected president-elect of the AMA by acclamation. He will become the AMA's 125th president at the Annual Convention of 1970 in Chicago.

Others elected unanimously by the House were M. Louise Gloeckner, M.D., Pennsylvania, as vice president and Russell B. Roth, M.D., Pennsylvania, as speaker of the House.

Sen. Murphy, Bayh At Seminar

Senator George Murphy, R-California, and Senator Birch Bayh, D-Indiana, will be the guest speakers at the annual KEMPAC Seminar on September 22 at the Grand Ballroom, Seelbach Hotel.

Events of the Seminar include a social hour at 6:00 p.m., dinner at 7:00 p.m., the program at 8:00 p.m., and dancing from 9:30 to 12:30 p.m.

1897 Graduate of UL Med School Dr. Bernard Asman, 97, Dies

Bernard Asman, M.D., father of KMA President Henry B. Asman, M.D., died Thursday evening, July 24, at St. Joseph Infirmary at the age of 97.

Doctor Asman, the oldest living graduate of the University of Louisville School of Medicine, graduated in 1897 when the school was known as the Kentucky School of Medicine.

A retired proctologist, Doctor Asman taught at the UL Medical School from his graduation until his retirement in 1947. He was accorded the rank of professor emeritus of proctology by the board of trustees of the University.

1st Multi-County Society Formed

The Kentucky Medical Association Board of Trustees on August 7 approved the formation of the Pennyrile Medical Society. This is the first multi-county society to be granted approval since the KMA Bylaws were changed in September of 1968 authorizing county societies to join together into a multi-society.

The new Pennyrile Society will bring into one organization the physicians of Caldwell, Christian, Muhlenberg, Todd and Trigg counties. Other counties wishing to take similar action should contact the Kentucky Medical Association Headquarters Office for any particular questions they might have.

AMA Lists 73 Kentucky Physicians at Annual Convention in New York

Kentucky was represented by 73 physicians at the 118th Annual Convention of the American Medical Association July 13-17 in New York City. According to registration records received from the AMA, the Kentucky physicians attending are as follows:

LOUISVILLE

Henry B. Asman, M.D.
J. R. Barnes, M.D.
John T. Bate, M.D.
Charles G. Bryant, M.D.
E. Dean Canan, M.D.
Norman K. Cohen, M.D.
David M. Cox, M.D.
M. R. Cronen, M.D.
Elbert L. Dennis, M.D.
Roy K. Diamond, M.D.
Herbert Dickstein, M.D.
William C. Durham, M.D.
Mary V. Franz, M.D.
Hoyt D. Gardner, M.D.
J. Thomas Giannini, M.D.
R. F. Greathouse, M.D.
D. P. Hall, M.D.
Delbert Hoffman, M.D.
Raymond Jones, M.D.
Robert C. Long, M.D.
Dorothy Y. Ma, M.D.
James F. Molloy, M.D.
Richard R. Nave, M.D.
James E. Parker, M.D.
Irving B. Perlstein, M.D.
C. Kenneth Peters, M.D.
Aaron Rabb, M.D.
William T. Rumage, Jr., M.D.
N. A. Saliba, M.D.
Carroll L. Witten, M.D.

LEXINGTON

James W. Bard, M.D.
Abba E. Borowich, M.D.
Brian P. Geoghegan, M.D.
Ward O. Griffen, Jr., M.D.
F. R. Lemon, M.D.
William G. Malette, M.D.
Lloyd D. Mayer, M.D.
William H. McBeath, M.D.
Charles S. Mooney, M.D.
Franklin B. Moosnick, M.D.
Michael D. Paris, M.D.
Joseph B. Parker, Jr., M.D.
Nicholas J. Pisacano, M.D.
James J. Rams, M.D.
Johnny Roy, M.D.
Benjamin F. Rush, M.D.
David B. Stevens, M.D.
Ben E. Watson, M.D.
William R. Willard, M.D.

OTHER CITIES

George S. Beard, M.D., Hartford
Richard A. Blair, M.D., Paducah
C. M. Blanton, M.D., Paducah
John A. Broyles, III, M.D., Fort Knox
Walter L. Cawood, M.D., Ashland
James L. Ferrell, M.D., Paris
M. M. Hall, M.D., Camp Posantic
Daryl P. Harvey, Glasgow
E. R. House, M.D., Henderson
William R. Jernigan, M.D., Madisonville
Wilfred F. Jones, Jr., M.D., Harlan
Allwyn J. Levine, M.D., Ft. Campbell
Arthur J. Nash, M.D., Jenkins
Earl P. Oliver, M.D., Scottsville
Thomas D. Pruitt, M.D., Harlan
John C. Quertermous, M.D., Murray
Fred C. Rainey, M.D., Elizabethtown
George C. Reed, M.D., Versailles
Charles C. Rutledge ,M.D., Hazard
Charles Shields, M.D., Ft. Knox
David Steinman, M.D., Harlan
Faull S. Trover, M.D., Madisonville
L. H. Wagers, M.D., Hazard
Ira F. Wheeler, M.D., Oneida

Miscellaneous Meetings Planned During KMA Annual Session

Many medical groups have planned meetings during the KMA Annual Meeting September 23-25. The time, date and place of meetings scheduled at press time are listed below.

Saturday, September 20

6:00 p.m. Board of Directors, Kentucky Physicians Mutual, Dinner, Pendennis Club

Sunday, September 21

12:30 p.m. KMA Board of Trustees, Luncheon meeting, Parlor A, Kentucky Hotel

5:00 p.m. Social Hour, University of Kentucky College of Medicine, Parlors B & C, Kentucky Hotel

Monday, September 22

8:00 a.m. KMA Awards Committee, Breakfast, Room 203, Kentucky Hotel

8:30 a.m. Orientation Program, New KMA Members, Mirror Room, Kentucky Hotel

9:00 a.m. KMA House of Delegates Meeting, Terrace Room, Kentucky Hotel

12 00 noon Kentucky Psychiatric Association Meeting, Room 202, Kentucky Hotel

12:30 p.m. Reference Committee Chairmen, Luncheon, Room 317, Kentucky Hotel

2:00 p.m. Six Reference Committee meetings, Parlors A,B,C, & D and Rooms 203 and 204, Kentucky Hotel

6:00 p.m. KEMPAC Reception, Seminar, Banquet and Dance, Grand Ballroom, Seelbach Hotel

Tuesday, September 23

7:30 a.m. Panel on Cancer, Breakfast meeting, Room 205, Kentucky Hotel

12:00 noon Kentucky Psychiatric Association Meeting, Room 202, Kentucky Hotel

12:00 noon Kentucky Obstetrical and Gynecologic Society, Social Hour and Luncheon, Mont Marte Room, Old House

12:00 noon KMA Board of Trustees, Luncheon meeting, Parlor A, Kentucky Hotel

4:00 p.m. Maternal Mortality Committee meeting in Room 101, Convention Center, upon adjournment of Kentucky OB-GYN Specialty Group meeting

5:30-7:15 p.m. KMA — Woman's Auxiliary Reception, Mirror Room, Kentucky Hotel

5:30 p.m. Kentucky Psychiatric Association, Social Hour and Dinner, Parlors B & C, Kentucky Hotel

6:30 p.m. Kentucky Dermatologic Society, Social Hour and Dinner, Pendennis Club

6:30 p.m. Kentucky Urological Society, Social Hour and Dinner, Oak Room, Sheraton Hotel

6:30 p.m. Kentucky Chapter, American Academy of Pediatrics, Social Hour and Dinner, Executive Inn

6:30 p.m. Kentucky Chapter, American College of Chest Physicians, Social Hour and Dinner, The Old House

Wednesday, September 24

9:00 a.m. State Board of Health meeting, Room 317, Kentucky Hotel

11:50 a.m. President's Luncheon, Flag Room, Kentucky Hotel

5:00 p.m. Board of Trustees meeting, Parlor B, Kentucky Hotel

5:45 p.m. Board of Trustees, Dinner, Parlor A, Kentucky Hotel

6:00 p.m. House of Delegates, Subscription Dinner, Terrace Room, Kentucky Hotel

7:00 p.m. House of Delegates, Terrace Room, Kentucky Hotel

Thursday, September 25

7:00 a.m. MEA Liaison Committee, Breakfast, Room 203, Kentucky Hotel

7:30 a.m. Kentucky Society for the Prevention of Blindness, Breakfast meeting, Parlor B, Kentucky Hotel

7:30 a.m. Kentucky Chapter, American Academy of General Practice, Breakfast meeting, Room 204, Kentucky Hotel

7:30 a.m. Atherosclerosis Panel, Breakfast, Room 202, Kentucky Hotel

7:30 a.m. School Health Panel, Breakfast, Room 205, Kentucky Hotel

10:00 a.m. Kentucky Diabetes Association Meeting, Mirror Room, Kentucky Hotel

11:00 a.m. Kentucky Chapter, American College of Surgeons meeting, luncheon, Parlor B, Kentucky Hotel

12:00 noon KMA Board of Trustees, Luncheon, Parlor A, Kentucky Hotel

12:00 a.m. Kentucky Society of Pathologists, Luncheon, Parlor C, Kentucky Hotel

12:15 p.m. Kentucky Industrial Medical Association, Luncheon meeting, Ship Room, Kentucky Hotel

12:30 p.m. Kentucky Diabetes Association Luncheon, Mirror Room, Kentucky Hotel

12:30 p.m. Kentucky EEN&T Society, Luncheon, The Old House

STAFF PHYSICIAN

Full time industrial physician for Frigidaire Division of General Motors Corporation, Dayton, Ohio. Medical staff includes three full time physicians and seventeen nurses.

Duties will include pre-employment physical examinations, treating occupational illnesses and injuries and assisting in overseeing a preventive health program for 18,000 employes.

Good starting salary, bonus plan and outstanding employe benefits. Relocation expenses paid. Contact J. L. Colglazier, M.D., Medical Director, Frigidaire Division, G.M.C., Dayton, Ohio 45401

AN EQUAL OPPORTUNITY EMPLOYER

Latest "Relative Value Studies" To Be Available October 1

The **Relative Value Studies (RVS)**, a complete listing of procedures performed by physicians, will be published this month by the California Medical Association. Designed to assist doctors, health insurance carriers, consumers and business to identify procedures which physicians perform, **RVS** will become effective for usage in California April 1, 1970.

More than 20 medical specialty subcommittees and a number of individual consultants and representatives of the insurance industry, component medical societies and computerized billing services were consulted in the compilation of this edition.

Copies of the revised **RVS**, at $3.50 each (including tax), will be available from Six-Ninety-Three Sutter Publications, Inc., 693 Sutter Street, San Francisco 94102. Prepaid orders will be filled beginning October 1.

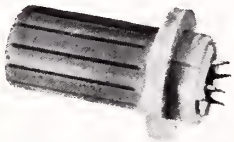
Dr. Stevens Gets Fayette Award

The Fayette County Medical Society presented David B. Stevens, M.D., Lexington, its first Outstanding Physician Award recently. The award, presented by Society President David A. Hull, M.D., is given for contributions to the community and the Society.

Doctor Stevens is assistant clinical professor of surgery at the University of Kentucky Medical Center and serves on the Medical Advisory Committee of the Frontier Nursing Service in Hyden. He also works with the Commission for Handicapped Children, Shriner's Hospital, Cardinal Hill Convalescent Hospital and Opportunity Workshop in Lexington.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

KMA Lawyer Named To Board

E. Gaines Davis, Jr., attorney for KMA, was installed to the Board of Governors at the annual convention of the Kentucky State Bar Association June 10-13.

Spindletop CWP Conference Set

A conference on coal workers' pneumoconiosis (CWP) will be sponsored by Spindletop Research, Inc. September 10-13 in Lexington. Specialists will confer in a closed session the first three days to discuss needed research in CWP. Attendance will be open on September 13 for anyone interested in discussing the conference results.

Twenty-three experts in pathology, epidemiology, diagnosis/evaluation, and physiology from England, Canada, Germany and the U.S. will meet in an attempt to seek an agreement as to the key medical problems associated with CWP. Under the direction of Spindletop consultants R.W.B. Penman, M.D., Lexington, and W. H. Anderson, M.D., Louisville, the conference will also attempt to structure an integrated research approach to CWP medical problems.

Prevention Services Offered

The Kentucky Society for the Prevention of Blindness is attempting to expand its community services state-wide. Two of the most adaptable programs the Society provides are Glaucoma Screenings and Pre-School Vision Screenings. Organization procedure, training film and materials, public education borchures, and training for volunteers is provided by the Society. Further information may be obtained through the Society office, 1102 Heyburn Building, Louisville, Kentucky 40202.

The Clinical Associate

(continued from page 680)

References

1. Stead, E. A., Jr., "Conserving costly talents-providing physician's assistants". *Journal of the American Medical Association* 198: 1108, December 5, 1966.
2. Kissick, W. L., Effective Utilization: The Critical Factor in Health Manpower. *American Journal of Public Health* 58: 23-29, January 1968.
3. Yankauer, A., Connelly, J. P., Feldman, J. J., A Survey of Allied Health Worker Utilization in Pediatric Practice in Massachusetts and in the United States. *Pediatrics*, 42: 733-741, November 1968.
4. Rice, D. I., The Future Use of Paramedical Personnel in Private Medical Practice. *Canadian Medical Association Journal*, 97: 1597, 1967.
5. Bergen, Richard P., Irregular Assistants and Legal Risks, *Journal of the American Medical Association*, 207: 1231-1232, February 10, 1969.

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass
cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

In Memoriam

HENRY T. ALEXANDER, M.D.
Frankfort
1889-1969

Henry T. Alexander, M.D., 79, a retired physician died July 15. A 1911 graduate of Eclectic Medical College in Cincinnati, Doctor Alexander had practiced in Crestwood from 1936 to 1967 when he retired and moved to Frankfort.

BERNARD ASMAN, M.D.
Louisville
1872-1969

Bernard Asman, M.D., 97, a retired Louisville proctologist, died July 24 at St. Joseph Infirmary. A 1897 graduate of the University of Louisville School of Medicine, Doctor Asman joined the school's staff and remained there until he retired in 1947. At retirement he was clinical professor and head of the department of proctology. He was awarded the rank of professor emeritus of proctology.

WILLIAM C. WOLFE, M.D.
Louisville
1909-1969

William C. Wolfe, M.D., 60, an ear, nose and throat specialist, died August 3 at his home. A 1936 graduate of the University of Louisville School of Medicine, he was a former head of the department of otolaryngology at that school. Doctor Wolfe was a member of the Medico Chirurgical Society, American Trilogical Society, Society for Plastic and Reconstructive Surgery and the American College of Surgeons.

OWEN M. WHEELER, M.D.
Louisville
1898-1969

Owen M. Wheeler, M.D., 71, a Louisville physician, died August 14. Doctor Wheeler graduated from the University of Louisville School of Medicine in 1923 and began practice at that time. During World War II he served in Army hospitals in Texas and Oklahoma.

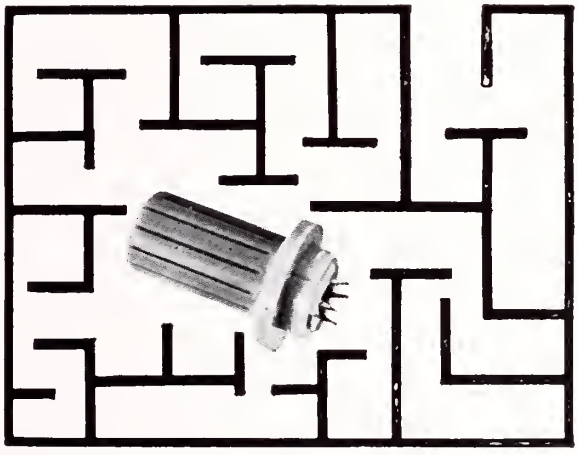
Urinary Tract Infection
(continued from page 664)

Summary

Chronic renal failure secondary to pyelonephritis in girls may be a preventable disease. Since the disease may be asymptomatic until the process is irreversible, detection of asymptomatic urinary tract infection provides a means of early recognition. Screening for asymptomatic bacteriuria in the physician's office or in large detection programs may be done economically and reliably by lay personnel using the miniplate culture method. Relatively unskilled paramedical personnel when properly instructed perform adequately in collecting clean specimens and innoculating cultures. All urines with greater than 100,000 bacteria/ml and 80 per cent with 10,000-100,000 bacteria/ml may be detected by this method. The Griess test was falsely negative three-fifths times and was not a valuable aid. Microscopic examination of the urine sediment was frequently inaccurate and is not practical in detection programs employing lay personnel.

REFERENCES

1. Kunin, C. M., Deutscher, R. and Paquin, A. J.: Urinary tract infection in school children: An epidemiologic, clinical and laboratory study, *Med. 43:* 91, (March) 1964.
2. Holland, Nancy H. and West, Clark D.: Prevention of urinary tract infections in girls, *Am. J. Dis. Child., 105:* 560, (June) 1963.
3. Hinkle, N. H., Partin, J. C. and West, C. D.: Diagnosis of acute and chronic pyelonephritis in children, *AJDC, 100:* 333, (Sept.) 1960.
4. Schaus, R.: Griess nitrate test in diagnosis of urinary infection, *JAMA, 161:* 528, (June) 1956.
5. Kessner, D. M. and Florey, C. V.: Mortality trends for acute and chronic nephritis and infections of the kidney, *The Lancet, 2:* 979, (Nov. 4) 1967.
6. Wharton, L. R., Gray, L. A. and Guild, H. G.: The late effects of acute pyelitis in girls, *JAMA, 109:* 1597, (Nov. 13) 1937.
7. Woodruff, J. D. and Everett, H. S.: Prognosis in uninary tract infections in girls, *Am. J. Obst. & Gyn., 68:* 798, (Sept.) 1954.
8. Steele, R. E., Leadbetter, G. W. and Crawford, J. D.: Prognosis of childhood urinary tract infection, *NEJM, 269:* 883, (Oct. 24) 1963.
9. Pryles, Charles V. and Neumann, Charlotte: Pyelonephritis in infants and children, *Am. J. Dis. Child., 104:* 215, (Sept.) 1962.
10. Spark, H., Travis, L., Dodge, W., Daeschner, C. W. and Hopps, H.: The prevalence of pyelonephritis in children at autopsy, *Ped., 30:* 737, (Nov.) 1962.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

Symbols in a life of psychic tension

M.A.

class of '66

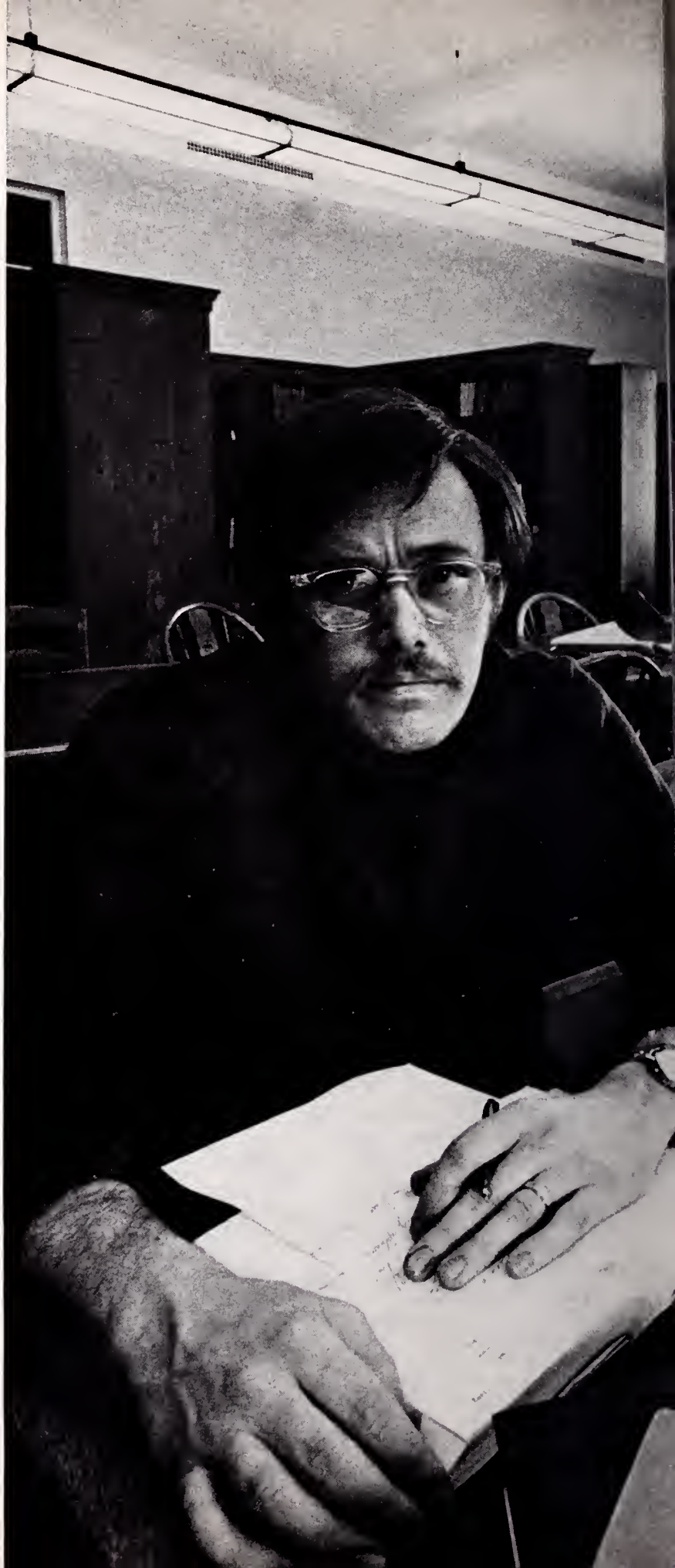
Ph.D.

thesis... in progress

G.I.

series and complete examination normal

(persistent indigestion)



ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

M. A. (class of '66)... Ph.D. (thesis, in progress)...letters that represent a young lifetime of work...a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish...a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an *h.s.* dose added to the *t.i.d.* schedule.

Valium is generally well tolerated. In proper maintenance dosage it seldom dulls the senses or interferes with functioning. Side effects most commonly reported have been drowsiness, fatigue and ataxia.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

to help relieve psychic tension
and its somatic symptoms

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1968-69

Officers

HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 President
WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665.....President-Elect
GEORGE F. BROCKMAN, 2 E. Main Cross, Greenville (502) 338-3660....Immediate Past President
EDWIN P. SOLOMON, JR., 910 Heyburn Bldg., Louisville (502) 585-4123.....Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661.....Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211.....Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282.....Vice-Speaker—House of Delegates
LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 Chairman of the Board of Trustees
GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552..Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. 5th St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255.....1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362..1971
5th District GEORGE A. SEHLINGER, 2312 Medical Arts Bldg., Louisville (502) 452-1552 1969
6th District REX E. HAYES, Glasgow (502) 651-5113 1969
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1969
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231.....1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406.....1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751.....1969
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155....1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357.....1969

Buyers Guide

SEPTEMBER BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Concer Society 681

Bristol Laborotories 674
Burroughs Wellcome 635

Compbell Soup 671

Frigidoire 695

Geigy Pharmaceuticals 638-639, 647, 656-657
General Leasing Corporation 633

Highland Hospital 687
Hynson, Westcott and Dunning 627

Lederle Laborotories 629, 687, 696, 699
Lilly, Eli and Company 658

McNeil Laborotories 652
Medical Protective Company 703
Merck Sharp & Dohme 682-684

Merrell, Wm. S. Company 641

National Drug Company 626, 645-646

Parke, Davis and Company 651, 675
Pfizer Laborotories 654-655

Riker Laborotories 632-633
Robins, A.H. Company 631, 685-686
Roche Laborotories 636-637, 700-701, 704

Sandoz Laborotories 676
Searle, G.D. And Company 672-673
Smith Kline & French Labs 690
Southern Optical Company 703
Strasenburgh Laborotories 653

Wallace Pharmaceuticals 642-644
Warner Chilcott 691-692
Wyeth Laborotories 697-698

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

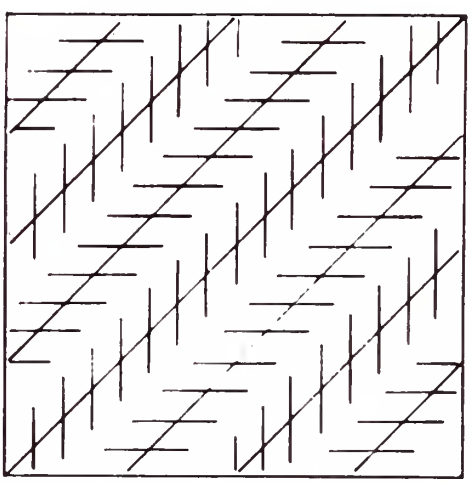
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Raad Mall Office Center
400 Sherburn Lane
Telephone: (Area Cade 502) 895-5501
Mailing Address: P.O. Bax 20065, Lauisville, Kentucky 40220

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



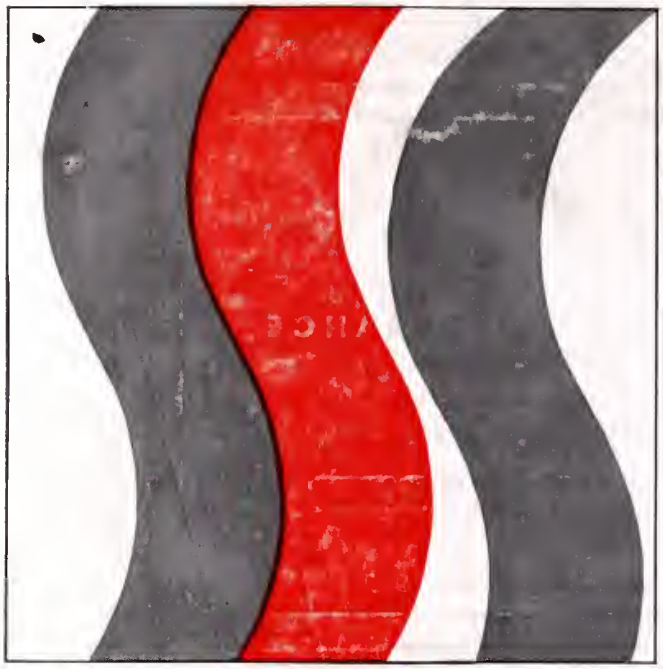
Charge accounts invited

Southern Optical

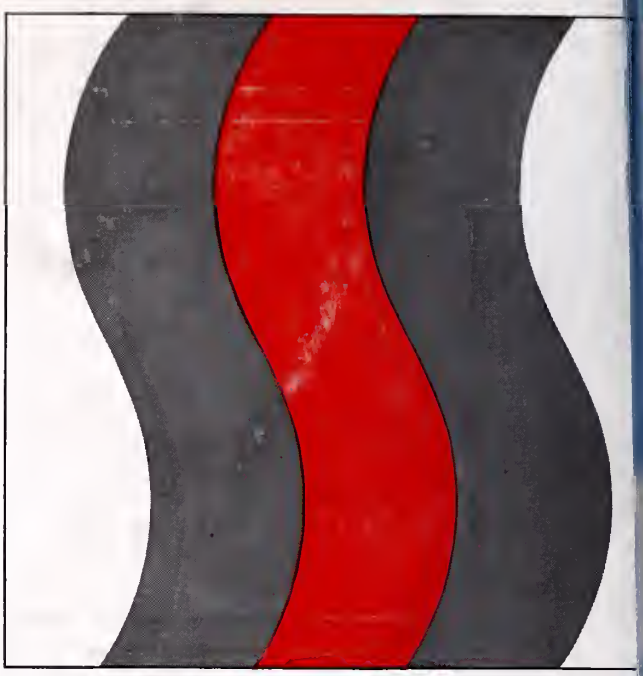
SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, o summary of which follows:

Indications: Indicated when onxiety, tension and opprehension are significant components of the clinical profile.

Contraindications: Potients with known hypersensitivity to the drug.

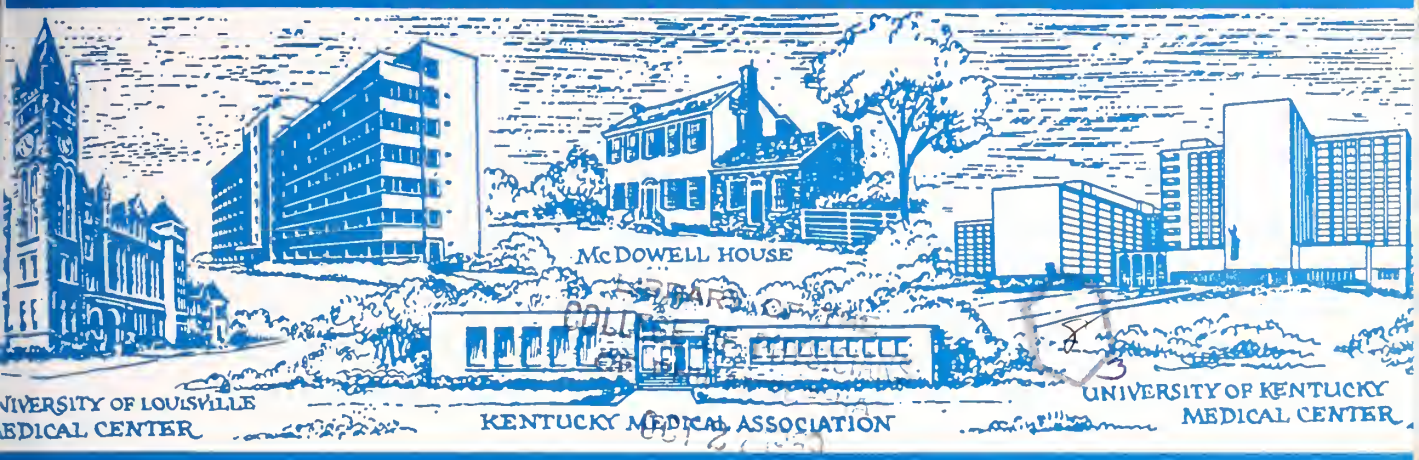
Warnings: Caution potients about possible combined effects with alcohol and other CNS depressants. As with all CNS-octing drugs, caution patients against hazordous occupotions requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence hove rorely been reported on recommended doses, use caution in administering to addiction-prone individuols or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuotion of the drug and similor to those seen with barbiturates, have been reported. Use of any drug in pregnoncy, loctotion, or in women of childbearing oge requires thot its potentiol benefits be weighed oganist its possible hazards.

Precautions: In the elderly ond debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually os needed ond tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation ond ocute rage) have been reported in psychiatric patients and hyperactive oggressive children. Emplor usual precautions in treatment of onxiety stotes with evidence of impending depression; suicidal tendencies moy be present and protective meosures necessary. Variable effects on blood coagulation hove been reported very rorely in patients receiving the drug ond orol anticoogulants; causol relotionship has not been estoblished clinicolly.

Adverse Reactions: Drowsiness, otoxia ond confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but ore also occosionolly observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edemo, minor menstrual irregularities, nausea and constipation, extropyramidal symptoms, increosed and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during ond after treatment; blood dyscrasias (including agranulocytosis), joundice and hepotic dysfunction hove been reported occosionolly, making periodic blood counts ond liver function tests advisoble during protrocted theropy.

VOLUME 67 OCTOBER 1969 NUMBER 10

The Journal of The KENTUCKY Medical Association



In This Issue

Kentucky Camp for Diabetic Children
Robert E. French, M.D. and Neal Sanders, M.D. 743

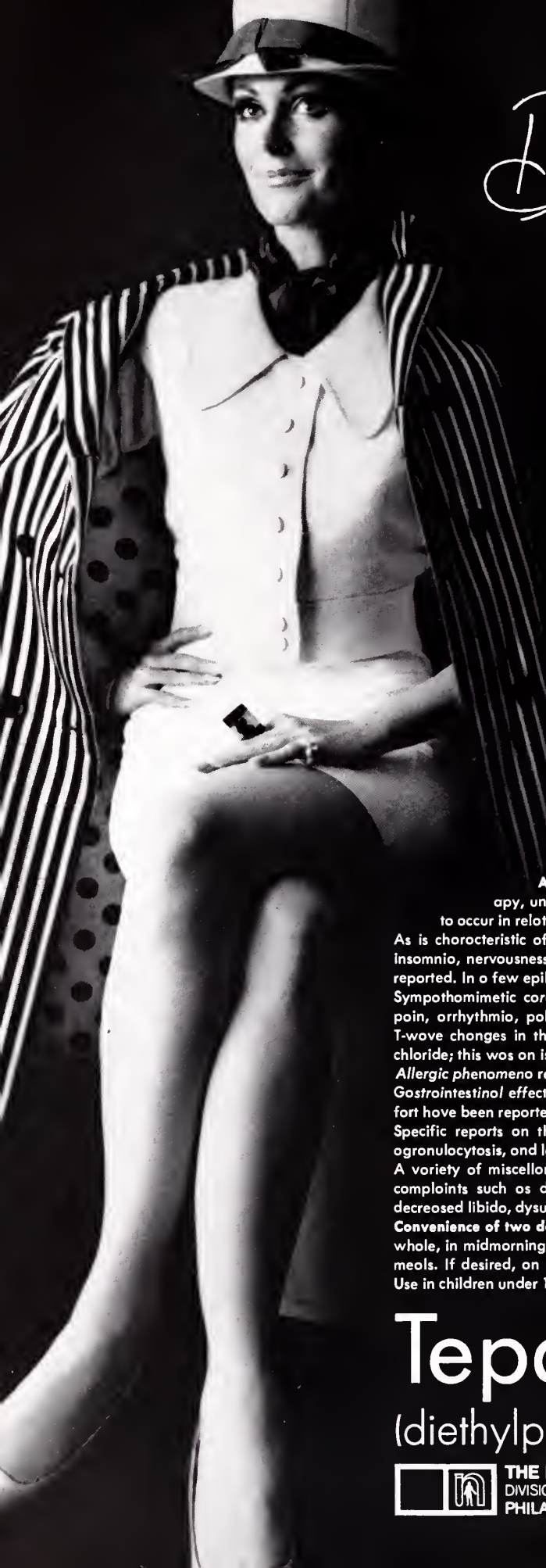
Deaths in a Small Community Hospital
Romeo S. Berardi, M.D. and Mary A. Hall, M.D. 749

Subarachnoid Hemorrhage
H. Martin Blacker, M.D., Horace A. Norrell, Jr., M.D. and Charles B. Wilson, M.D. 752

Special Article

Presidential Address 763

Complete Contents on page 708



Dear Doctor, You made me what I am today - a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in potients hypersensitive to this drug; in emotionolly unstoble potients susceptible to drug obuse.

Warning: Although generolly sofer thon the omphetamines, use with greot coution in potients with severe hypertension or severe cardiovoscular diseose. Do not use during first trimester of pregnoncy unless potentiol benefits outweigh potentiol risks.

Adverse Reactions: Rorely severe enough to require discontinuotion of therapy, unpleosont symptoms with diethylpropion hydrochloride hove been reported to occur in relotively low incidence.

As is chorocteristic of sympothomimetic ogents, it moy occosionolly couse CNS effects such os insomnio, nervousness, dizziness, onxiety, ond jitteriness. In controst, CNS depression hos been reported. In o few epileptics on increose in convulsive episodes hos been reported.

Sympothomimetic *cordiovosculor effects* reported include ones such os tochycordio, precordial poin, orrhythmio, polpitotion, ond increosed blood pressure. One published report described T-wove chonges in the ECG of a heolthy young mole after ingestion of diethylpropion hydrochloride; this wos on isoloted experience, which has not been reported by others.

Allergic phenomeno reported include such conditions as rash, urticorio, ecchymosis, ond erythemo.

Gostrointestinol effects such os diorrheo, constipotion, nouseo, vomiting, ond obdominol discomfort hove been reported.

Specific reports on the hemotopoietic system include two eoch of bone morrow depression, ogronulocytosis, ond leukopenio.

A voriety of miscelloneous odverse reoctions hove been reported by physicions. These include complaints such os dry mouth, heodoche, dyspneo, menstruol upset, hoir loss, muscle pain, decreosed libido, dysurio, ond polyurio.

Convenience of two dosage forms: TEPANIL Ten-tab toblets: One 75 mg. toblet doily, swallowed whole, in midmorning (10 o.m.); TEPANIL: One 25 mg. toblet three times doily, one hour before meols. If desired, on odditionol toblet moy be given in midevening to overcome night hunger. Use in children under 12 yeors of oge is not recommended.

Tepanil® Ten-tab®

(continuous release form)

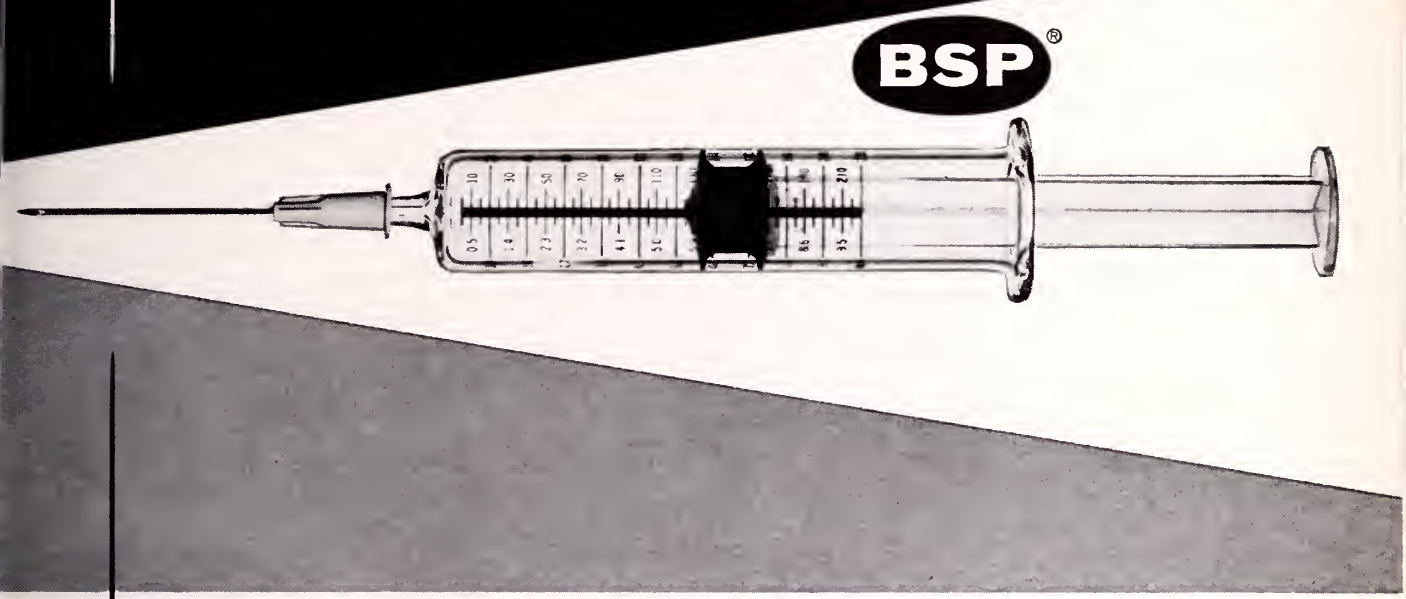
(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/69

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D

Baltimore, Maryland 21201

(BSP04)

Volume 67 • October 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Diane Maxey

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Cose Discussions
Lewis Dickinson, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1972
Richard R. Crutcher, M.D.
Chrisman S. Jackson, M.D.
E. Truman Mays, M.D.
Joseph Parker, Jr., M.D.
Elmer G. Prewitt, M.D.
Carl E. Rutledge, Jr., M.D.
Winston Rutledge, M.D.
A. Franklin White, M.D.

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Thelss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D
Ray A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
John H. Willard, M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Kentucky Camp for Diabetic Children
Robert E. French, M.D. and Neal Sanders, M.D. . . .743

Deaths in a Small Community Hospital
Romeo S. Berardi, M.D. and Mary A. Hall, M.D. 749

Subarachnoid Hemorrhage
H. Martin Blacker, M.D., Horace A. Norrell, Jr., M.D. and Charles B. Wilson, M.D. 752

SPECIAL ARTICLE

Presidential Address 763

EDITORIALS

The New Physician
Walter S. Coe, M.D. 772

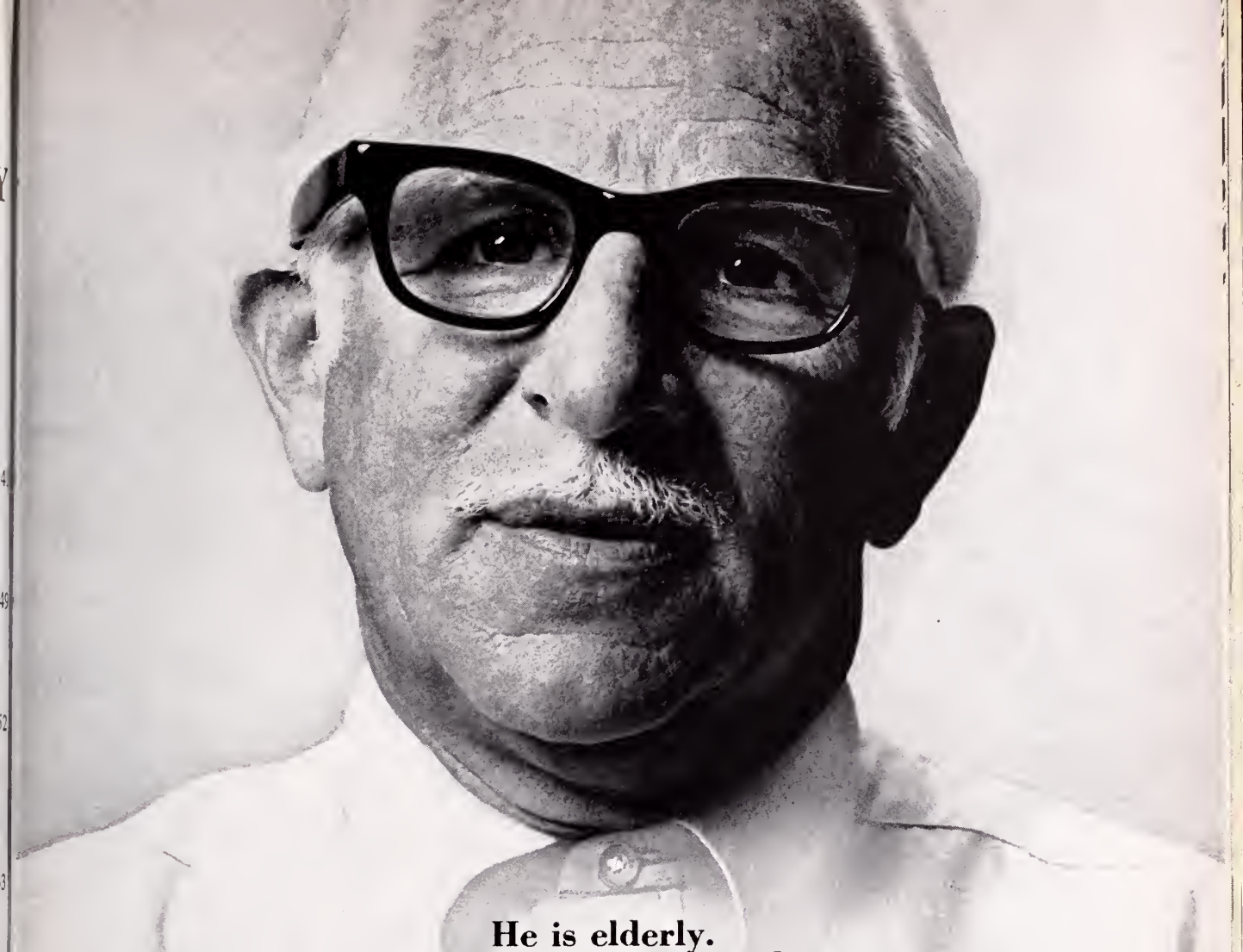
The S.M.A. in Atlanta
Sam A. Overstreet, M.D. 773

ORGANIZATION

November Lecture to Honor Doctor Sidney Johnson 779
Continuing Medical Education Now Presented in TV Series 779
Transplant Surgeon to Deliver L. E. Smith Lecture Nov. 6 779
Ky. Thoracic Society Conference Features Lung Transplants, TB 779
AMA Approves 2-Year Curriculum For Medical Assistants 780
KMA Adds 28 Physicians To Its Membership 780

REGULAR FEATURES

President's Page 710
Postgraduate Opportunities . .714
In The Books 717
Insurance Page 721
Maternal Mortality 724
Medical Progress 730



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300 b.i.d.

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



Thanks

I AM grateful to the Kentucky physicians for bestowing the presidency upon me for 1969-70. The physicians are challenged as never before in history. It is pleasing to accept this challenge in our fast-changing world. During this year, I shall call upon many of you. Others will be asked to contribute through committees and committee chairmen to perform for our patients and medicine. My plea is that you do your jobs well. KMA's success this year will depend upon you.

Many areas require work and performance. One of the most important is citizenship because the central government grows ever stronger and promulgates more regulations and rules. Consequently, all citizens and especially physicians, must participate in government. "Government is enduring, if not enchanting."

The vast amount of knowledge today is ever increasing. It is easy for physicians to be caught in the trap of too much to do and learn in too little time. All physicians must find a way to continue their education. Dwight Wilbur, M.D., past AMA president said, "Each physician must be willing not only to learn but to unlearn. If he is not, he does not deserve to be a physician."

When selected as president-elect of KMA, I said that I do not feel that physicians or any group of citizens can remain in a vacuum in this world today. Doubters become believers when it is learned that 56 billion dollars was spent on health care and all its facets in 1968. The doctor, the lawyer, the candlestick maker and all citizens are interested in 56 billion dollars. Physicians must enter into discussion with insurance carriers, labor, government and the public. Physicians who do not participate and are indifferent could be responsible for the shackling of our profession.

Later this year, I shall stress concern about, not only patient care, but continuing medical education, citizenship, manpower, planning and financing medical care.

Walter L. Cawood



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

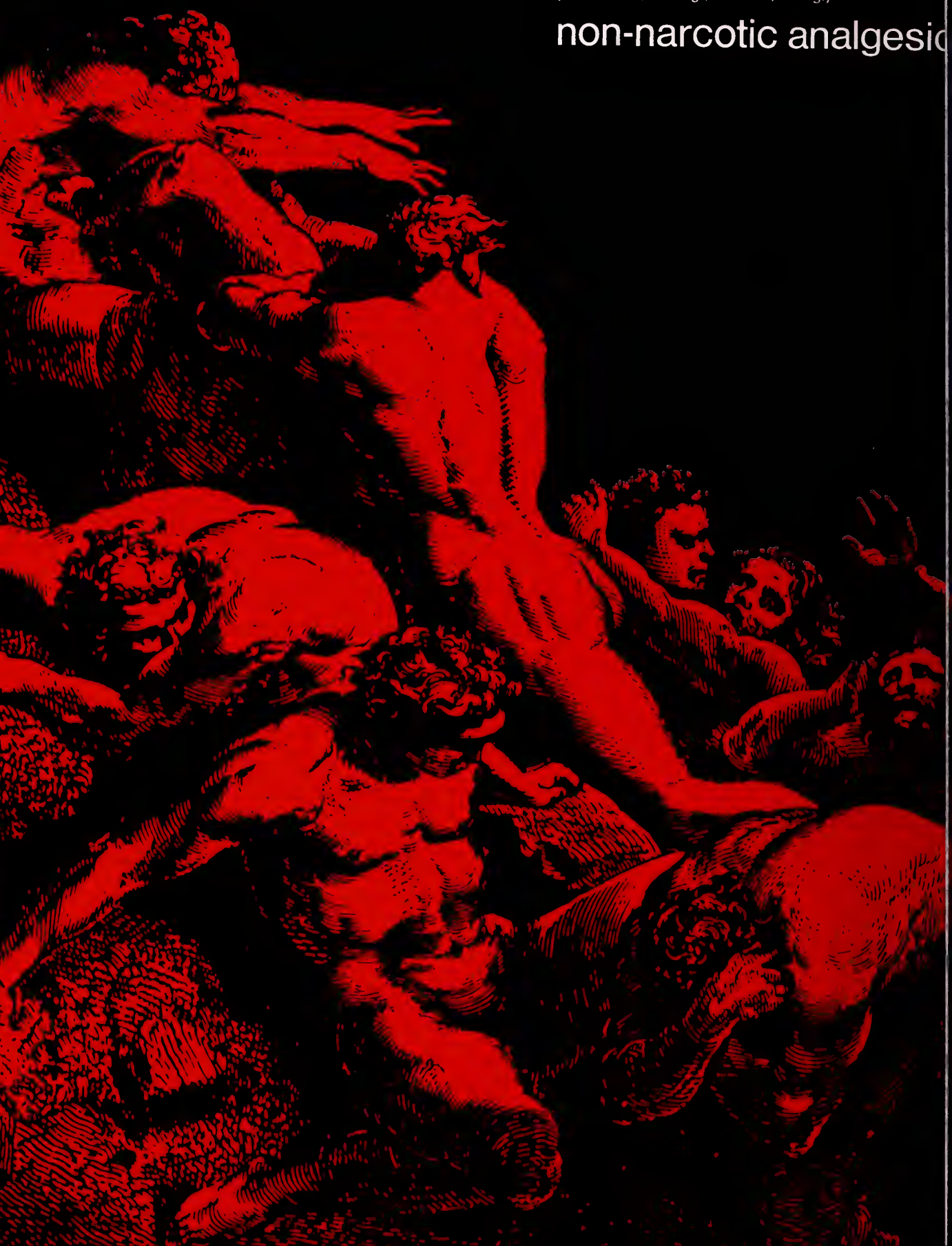
You might also say that all interns aren't alike, either.



NORGESIC

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

non-narcotic analgesic



r musculo-skeletal pain,

y Norgesic first...

of 10 patients probably won't
eed anything stronger

ORGESIC offers predictable relief in approxi-
ately 80% of patients with painful musculo-
eletal disorders. It provides *both* effective
ialgesia and relief of associated muscle
asm. NORGESIC works quickly, usually pro-
ucing a high level of analgesia within two
ours, and relief is sustained for four hours or
nger.

For the relief of acute mild to moderate pain
ssociated with musculo-skeletal disorders,
y NORGESIC first...eight of ten patients proba-
y won't need anything stronger.

Indications: Symptomatic relief of acute mild to moderate
in of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect
orphenadrine, NORGESIC should not be used in patients with
aucoma, pyloric or duodenal obstruction, stenosing peptic
cers, prostatic hypertrophy, obstructions at the bladder neck,
halasia (megaesophagus), myasthenia gravis or in patients
own to be sensitive to aspirin, phenacetin or caffeine. Do
t use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of
is preparation in pregnancy, during lactation, or in the child-
earing age has not been established, use of the drug in such
atients requires that the potential benefits of the drug be
eighed against its possible hazard to the mother and child.
USE IN CHILDREN: The safe and effective use of this drug
children has not been established; therefore, the physician
ust weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged
xcessive use of phenacetin may result in nephrotoxicity.
aution should therefore be exercised when administering
ORGESIC to patients with renal insufficiency. It should also be
sed with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usu-
lly associated with APC or mild anticholinergic agents. These
ay include tachycardia, palpitation, urinary hesitancy or re-
ention, dry mouth, blurred vision, dilatation of the pupil, in-
reased intraocular tension, weakness, nausea, vomiting,
eadache, dizziness, constipation, drowsiness, and rarely,
rticaria and other dermatoses. Infrequently, mental confusion
n the elderly, mild central excitation and occasional halluci-
ations. These mild side effects are usually eliminated by re-
uction in dosage. One case of aplastic anemia, with no
stablished causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4
imes daily.

For more detailed prescribing information,
ee Package Circular or PDR.

NORGESIC®

orphenadrine citrate, 25 mg., aspirin, 225 mg.,
henacetin. 160 mg., caffeine. 30 mg.)

non-narcotic analgesic

Riker Laboratories, Northridge, California 91324
Div. Dart Industries Inc.

Sponsors of Riker Service—
he complimentary classified service for physicians.

LEASING

TAILORED FOR

Doctors!

The quickest, easiest,
most economical way to
acquire a car.

Conserve your precious time and keep your cash!

Let us do your
Car shopping for you!
(Any make or model)

WE ALSO LEASE
Medical & Surgical Equipment
and Office Furnishings

Why Make a Capital Investment?

General
LEASING

CORPORATION
A DIVISION OF KOSTER-SWOPE, INC.

3712 FRANKFORT AVENUE

Louisville—St. Matthews

897-1641 **895-2451**

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

OCTOBER

17-19 Kentucky Academy of General Practice seminar, Park Mammoth Resort, Park City.

26-30 Medical Library Association, Brown Hotel, Louisville

29-Nov. 1 Training course on emergency care and transportation of sick and injured persons, sponsored by American Academy of Orthopedic Surgeons, University of Kentucky Medical Center, Lexington

31-Nov. 1 Surgical Care in Trauma, University of Kentucky Medical Center, Lexington

NOVEMBER

6 L. E. Smith Lecture, University of Kentucky Medical Center, Lexington

6-7 Third Annual Newborn Symposium, Department of Pediatrics, University of Louisville School of Medicine, Louisville

7-8 Kentucky Thoracic Society, Fall Scientific Session, Boone Tavern, Berea

IN SURROUNDING STATES

OCTOBER

18-23 American Academy of Pediatrics, 38th Annual Meeting, Palmer House, Chicago, Ill.

23-25 Conference on Surgery, University of Iowa, Iowa City, Iowa

23-25 Southeastern Chapter of the Society of Nuclear Medicine, 10th Annual Scientific Meeting, Sheraton Nashville Hotel, Nashville, Tenn.

31-Nov. 3 Annual Meeting, Association of American Medical Colleges, Cincinnati Convention Center, Cincinnati, Ohio

NOVEMBER

10-13 Southern Medical Association, 63rd Annual Meeting, Atlanta, Ga.

12-15 Third Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach", Tides Hotel and Bath Club, Redington Beach, Florida.

12-13 Postgraduate course, "Diseases of the Small Intestine and Colon", Cleveland Clinic Educational Foundation, Cleveland.

DECEMBER

6-11 Annual Meeting, American Academy of Dermatology, Bal Harbour, Florida

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

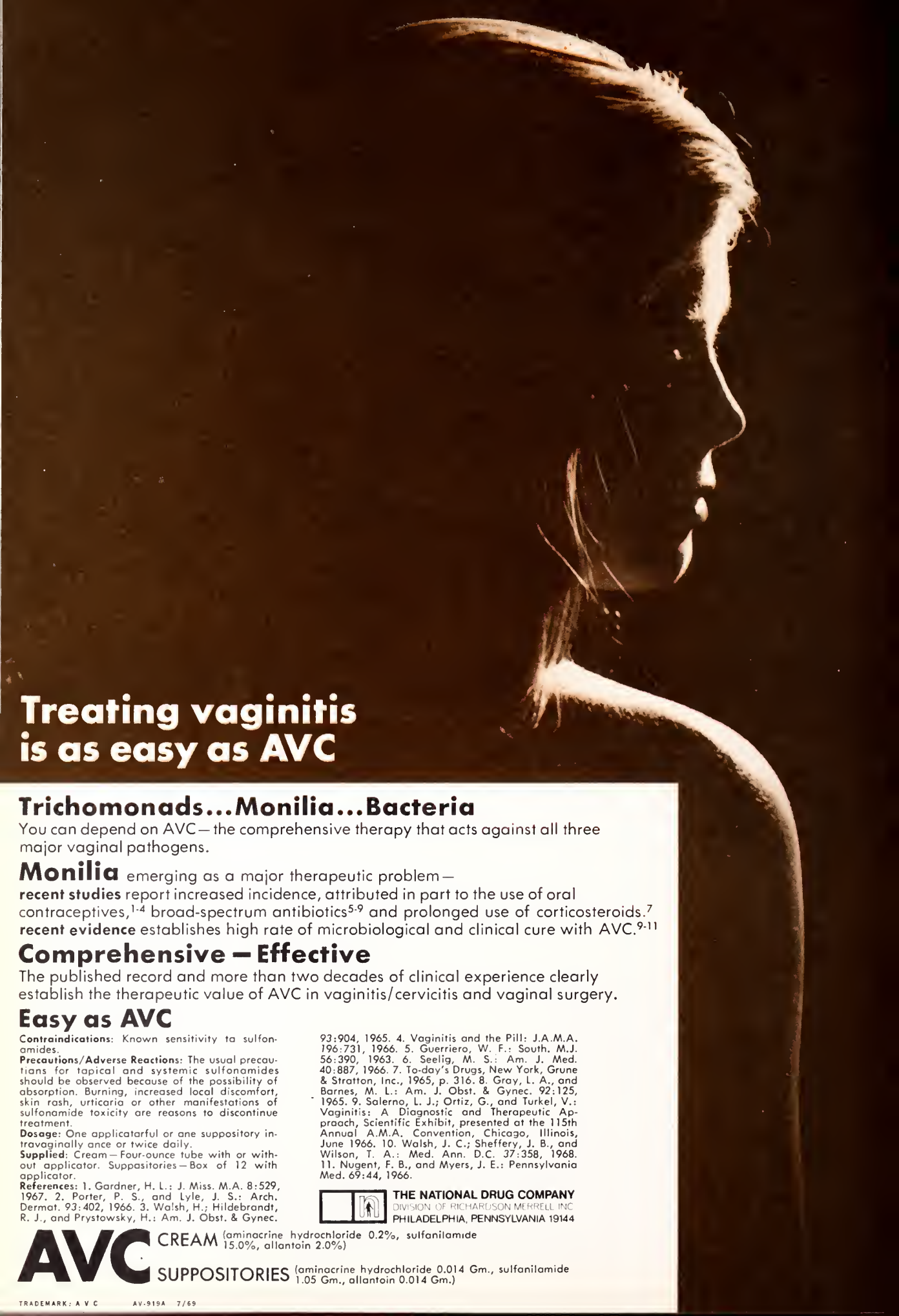
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., ominophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautians for tapical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatarful or ane suppository intravaginally ance or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppasitories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69



MEDICAL INTERVIEWING: A PROGRAMMED MANUAL: by Robert E. Froelich, M.D. and F. Marion Bishop, Ph.D., M.S.P.H.; Published by C. V. Mosby Company, St. Louis, 1969; 116 Pages; Price $4.75.

In this valuable book the authors employ the concepts of programmed learning to demonstrate the general principles of medical interviewing in realistic and readable scenarios. In addition they focus upon such specific clinical problems as evaluating sensorium, assessing suicidal potential, obtaining sexual information, closing the interview and handling gift offers from patients.

The authors present with insight and humor a wealth of vivid examples, in refreshing contrast to the arid generalizations too often found in discussions of interviewing. The programmed format particularly lends itself to an examination of the *incorrect* maneuver and its consequences—one is permitted to learn from an error without having actually committed it.

Above all, the authors keep consistently before the reader an awareness that the physician-patient relationship is an *interpersonal* transaction and that skilled interviewing is a uniquely human medical function which could never be supplied by the most advanced computers.

The text is perhaps too rigidly schematized in definitions of interview stratagems, and some of the authors' distinctions between programmed alternatives seem excessively subtle. But these shortcomings are trivial in comparison with the merits of the book.

In its clarity, thoroughness, detail and compassion this book should prove particularly valuable as a basic text for the medical student and the beginning practitioner of medicine. Indeed, as a needed counterbalance to the dehumanizing pressures of a technological society, it contains a lesson for us all.

GERALD L. MOORE, M.D.

1969 CURRENT THERAPY: by Howard F. Conn, M.D.; Published by The W. B. Saunders Company, Philadelphia, 1969; 945 Pages; Price $15.00.

The treatment of a patient is always a complex problem involving not only knowledge of anatomy, biochemistry and physiology, but also the knowledge of the disturbances that might have occurred in these areas as a result of the patient's illness. This knowledge obviously would not be satisfactory unless there is thorough knowledge of different drugs and manipulations that might be employed to modify the disturbances that have occurred. However, drugs, in altering the etiological agent, often disturb the patient and these disturbances must be anticipated and prevented if therapy is to be successful.

Moreover, every physician realizes that an illness is not isolated to an organ or even a system, but an illness results in changes in the total patient: physical, chemical, as well as psychological; and the patient's illness has an impact on the immediate surrounding society consisting of his family, friends, his employees and/or employer.

Consequently, treatment of a patient involves and affects not only the patient himself but all these other areas; and they all must be under the surveillance of the physician during treatment, if treatment is to be effective and complete. Since each patient and his illness is uniquely different, so each therapeutic regimen must be individually tailored.

It is because a patient with an illness is not a simple mathematical problem or a simple biological system that no book on treatment could ever truly serve to meet a physician's needs, and all books which aim at providing or describing effective programs of treatment are inadequate. It is the inherent difficulty of the subject which precludes any book from being written which even approximates the complicated requirements of the physician caring for a patient.

The *1969 Current Therapy* is the most recent of a long series of publications which has been accepted as a standard for comparison for this type of book. This book is well organized into sections according to the principal systems affected by the different diseases. The sections are written by men knowledgeable in the field, and the programs of treatment proposed are usually standard, and, therefore, untailored to the requirements of any single individual. One can legitimately question the scientific validity of certain therapeutic programs proposed, but this is to be expected in any book of this type. Despite these serious limitations, *1969 Current Therapy* might usefully serve the physician as a book of first recourse in preparation for a more in-depth survey of an illness.

In this regard, the value of the book could have been significantly enhanced by the inclusion of a brief the principal systems affected by the different diseases. in order to provide the reader with an opportunity to pursue the subject with greater ease at the first opportunity. Its great advantage, however, lies in the ready availability of a book clearly restricted to the subject of treatment to which the physician can quickly refer and thus serve to identify major highlights in the care of the patient. To use this book in any other way, I think, would be too superficial, and for this reason even dangerous.

ANGELO A. CILIBERTI, M.D.

THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to self esteem, *both* anxiety and depression almost always follow.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co., Inc., West Point, Pa. 19486
where today's theory is tomorrow's therapy



THE INSURANCE PAGE



Usual and Customary—Shall We Participate?

AT the Interim Meeting of the Kentucky Medical Association, March 27, 1969, in Lexington, an excellent address was given by George Dunlop, M.D., president of Massachusetts Medical Service. This article was printed in full in the May issue of the KMA Journal. This article presented well the problems which confront medicine and Blue Shield, and presented some of the solutions.

Here in Kentucky, the Blue Shield plan is growing in strength and effectiveness from day to day, due to the continuing cooperation of the State Medical Society. In other states the partnership between the medical societies and the Blue Plans have not gone so well. In the August issue of *Private Practice, the Journal of the Congress of County Medical Societies,* it was pointed out that many state medical societies were "singing the blues". It appears that the physicians had lost the initiative in direction of the Blue Plans. This was especially so in states in which Blue Cross and Blue Shield were administered jointly, since there seems to be a national trend in Blue Cross toward support of closed panel prepaid medical groups.

It must be pointed out that a partnership is a cooperation and mutual endeavor brought about by understanding and open discussion of the problems.

In the July issue of the KMA Journal, there appeared on this page an editorial entitled "Usual and Customary".

The article pointed out that there had been a demand by consumer groups for paid-in-full benefits and that experience to date indicates that the Blue Shield program has been working and working well, with less than one-half of one percent being referred to review committees.

Although this plan has the full support of the KMA Advisory Committee to Blue Shield and the KMA Board of Trustees, it apparently does not have the full support of each and every physician in Kentucky. This has been illustrated by resolutions from several county medical societies led by the Fayette County Medical Society in calling our attention to the fact that this program is a paid-in-full program and that if the physician chooses to cooperate in this program, he must accept the fee paid by Blue Shield.

Physicians, by tradition, have been rugged individualists and it has always been a principle of medical thought that no third party has the right to set the fee for physicians. Under the Usual and Customary Fee principle, the majority of physicians are actually setting their own fee. It is the exceptional case in which Blue Shield objects to a fee and in most incidences those cases that have been referred to a review committee have been illustrations of misunderstanding between the physician and Blue Shield. Since the resolution by the Fayette Medical Society has been circulated, Blue Shield has written to each member of KMA, requesting that he sign a statement of participation in the Usual and Customary Fee Program. The agreement between Blue Shield and the participating physician may be terminated at any time by writing a request to Blue Shield to terminate the agreement. The physician has free choice in this matter and if he elects not to participate, he is to make his usual Blue Shield Claim when treating the patient, but the payment will be

(Continued on Page 784)

Pertofrane® desipramine hydrochloride

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions: The following have been reported: *Nervous System*: dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract*: anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin*: skin rashes (including photosensitization), perspiration and flushing sensations. *Liver*: rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements*: bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System*: orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System*: urinary frequency or retention and impotence. *Endocrine System*: occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity*: urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability: Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Coming out of a depression

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood... a restoration of psychomotor activity. Patient usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the respor

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available

It's beautiful!



From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 1-67. This 35 year old married white gravida 5, para 4 was under the care of a private physician. Expected date of delivery was December 15, 1966.

She was admitted to the hospital October 20, 1966, with a history of noticing for the past month a 3 cm. mass in the lower outer quadrant of the left breast. It was non-tender. There was no nipple discharge. There was a less discrete mass in her right breast.

Examination revealed this mass in the left breast to be discrete, 3 cm. in diameter, subcutaneous, and not attached to the skin. There was no nipple retraction. No axillary or supraclavicular lymph nodes were palpable. On the right breast in the lower portion there was a more diffuse area of induration, there was no skin or nipple retraction and no axillary or supraclavicular nodes palpable.

Another surgical consulation advised that the lesion in the left breast should be biopsied by excision, and the area on the right breast biopsied either by excision or by incising it and obtaining frozen section. Further management would depend on these findings.

Chest x-ray showed the heart and mediastinal structures normal, hilar areas normal, lung fields were adequately aerated and clear. X-ray of the thoracic spine showed destruction of the proximal end of the left clavicle, partial wedging of T9 and T12. The remaining vertebral bodies appeared to be intact, the pedicles were intact, other than those involving T9 and T12. The lumbar spine revealed a single fetus in the cephalic presentation, there was some destruction and collapse of L5, the remaining lumbar vertebral bodies were intact. Normal gas pattern. The impression from x-ray was that these destructive lesions involved T9, T12, and L5. The left clavicle lesion was consistent with diffuse metastatic disease.

The area in the left breast was then biopsied October 21, it was the size of a lemon. The mass was hard and firm and grossly appeared to be cancer. A frozen section diagnosis revealed scirrhous carcinoma.

Because of the presence of metastatic disease, a radical mastectomy was not done at this time.

Obstetrical consultation was obtained and pelvic examination revealed the uterus consistent with that of a 33 to 35 week gestation. The fetal heart was present, the cervix was uneffaced and closed. It was felt that since radical surgery was undesirable for the breast malignancy, the patient should be delivered by Cesarean section, and have bilateral oophrectomy performed followed by chemotherapy.

On October 26, using pentothal, cyclopropane, a transverse incision was made in the lower uterine segment and a five pound, nine ounce girl was delivered. The baby cried spontaneously. The uterus was closed and a bilateral oophrectomy done. The patient left the operating room in good condition.

The patient's postoperative course was uncomplicated and the infant was discharged with the mother November 6.

The patient was seen in consulation for chemotherapy postoperatively, and it was felt that this should be delayed for approximately four weeks. However, androgen therapy was started initially and then treatment with Prednisolone and 5 Fluo-ouracil instituted.

She was readmitted to the hospital December 1, 1966, complaining of back pain. At this time the sternal end of the left clavicle was found to be enlarged and tender. The impression was metastatic carcinoma. Hemoglobin was 9 grams with a normal white count and normal differential. The urine was negative.

It was felt at this time that Leukeran and Prednisolone would be the treatment of choice. She also received intramuscular iron. She was discharged December 4, by wheel chair to her home.

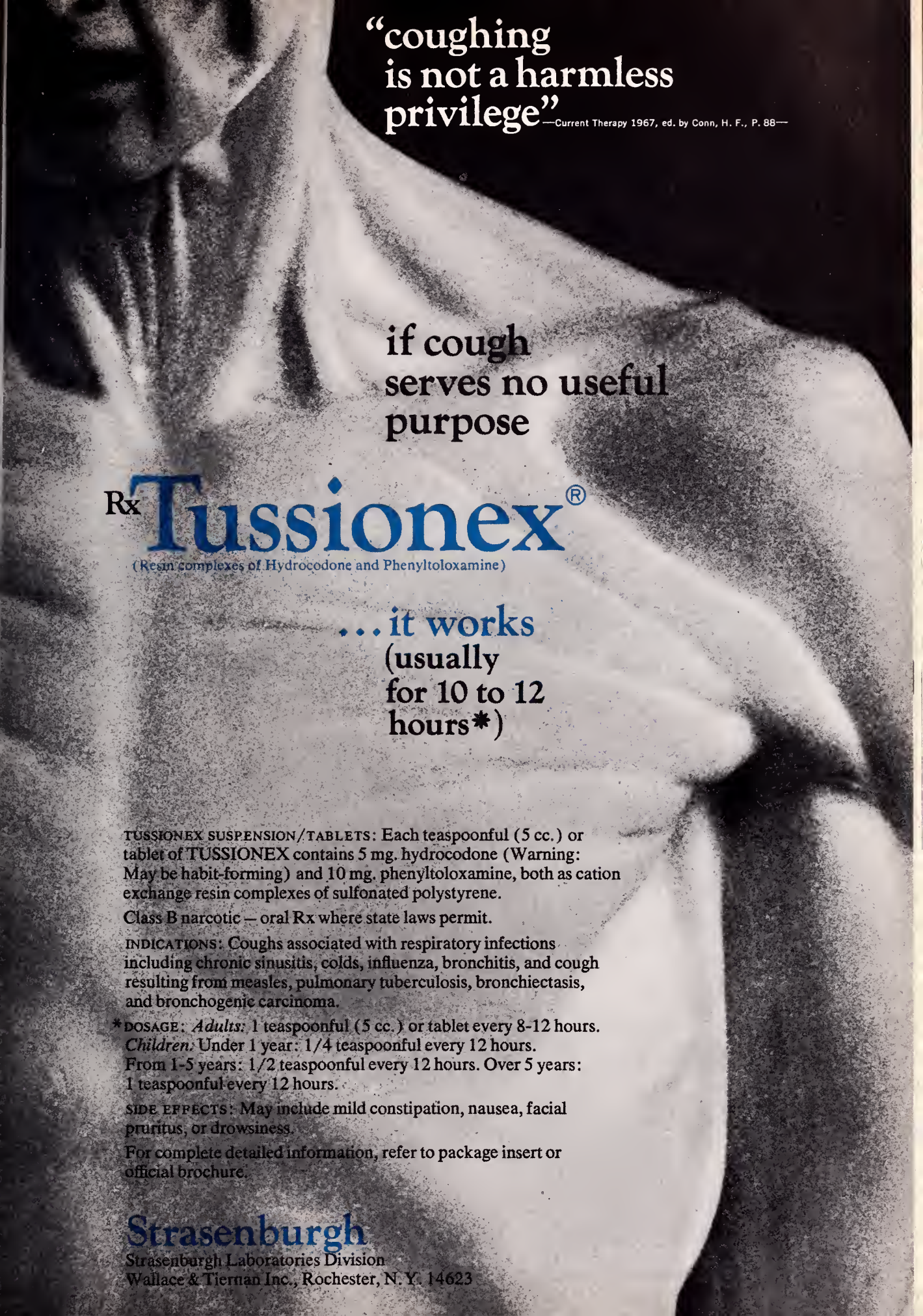
She was readmitted December 27 when she developed abdominal ascites. Abdominal paracentesis was done with removal of fluid. The patient became jaundiced. Her count was 7.4 grams hemoglobin, 2,580,000 red cells, hematocrit 24 per cent. The white count was 6,250 with a normal differential, 63 segs and 35 lymphs. She was transfused with 1000 cc of whole blood. The jaundice increased January 2 and she complained of chills. She became stuporous on January 3 with difficulty in breathing. She was placed in an oxygen tent but expired at 3:38 a.m. January 3.

The final diagnosis was adenocarcinoma of the breast with metastasis.

Comments

The Committee classified this as an indirect obstetrical death with probably no preventable factors. This case demonstrates the importance of patient education as to self breast examination and of a complete initial physical examination during prenatal care. These may have allowed earlier diagnoisis of

(Continued on Page 781)



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic – oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

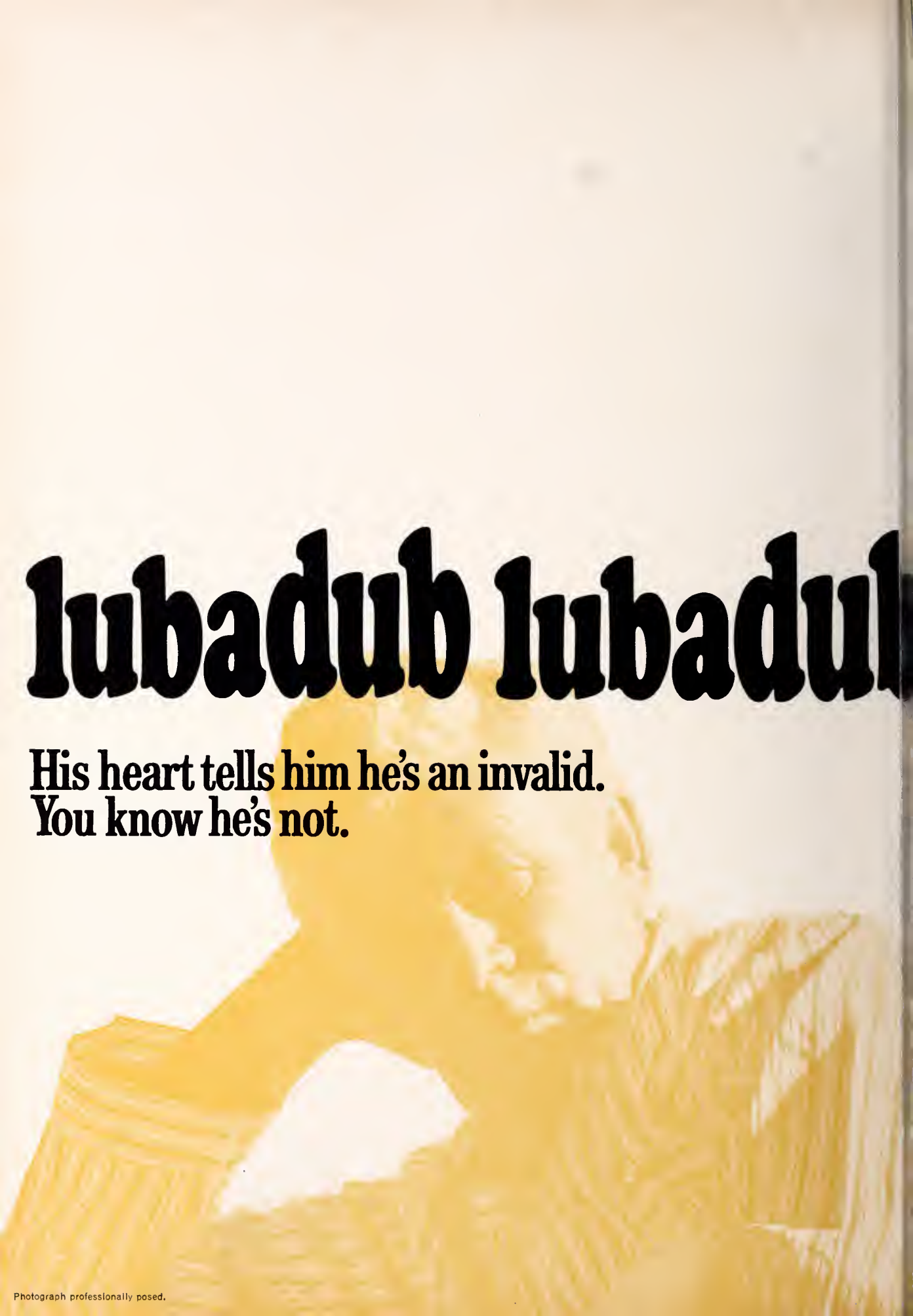
For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ibadubdub lubadu

nxiety is expected in the cardiovascular patient.
little may even be desirable.

ut when anxiety is exaggerated . . . when it
terferes with sleep . . . when it aggravates
ardiovascular symptoms, your help may
e needed.

aturally, you'll want to reassure the patient.

nd perhaps prescribe Equanil (meprobamate)
s adjunctive therapy. It helps relieve anxiety
nd tension specifically, yet gently.

lmost 15 years' use has shown that Equanil
usually well tolerated as well as effective.
de effects are generally limited to transient
rowsiness; serious, therapy-interrupting
de effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®



No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

WHAT'S NEW

in

Medical Progress

The Surgical Management of Chronic Duodenal Ulcer

WARD O. GRIFFEN, JR., M.D., PH.D.*

"A great step towards independence is a good-humored stomach"

Seneca, ca 50 AD

THE surgeon is often called upon to treat patients who are suffering from duodenal ulcer disease. Little controversy exists about the management of the more dramatic complications of duodenal ulceration. The perforation is closed; the hemorrhage stemmed; and the obstruction relieved. By far the most frequent reason for performing surgery on a duodenal ulcer goes under the name of intractability. It may be intractability of the disease, the patient, or the doctor. When no emergency is present, the procedures are elective, and the surgeon has time to inquire into the events leading to the development of the ulcer. If so inclined, he may measure the acid output of the gastric mucosa. The surgical task, then, is to restore "a good-humored stomach."

Despite the myriad etiologic factors, the varied acid secretory pattern, and the poorly-understood protective role of mucus in patients with duodenal ulcer, surgical therapy has been directed at a reduction of gastric acid putput. The procedure of choice is often dependent more on where or when the surgeon trained rather than on a scientific evaluation of the patient's disease. This report will review the history of the surgical management of duodenal ulcer culminating in the current-day controversy and attempt a look into the future.

Background[1,2,3]

Gastrojejunostomy marks a milestone in abdominal surgery. It was first used to bypass an unresectable, obstructing carcinoma of the stomach. Wolfer, one of Billroth's assistants, performed the antecolic gastrojejunostomy in 1881 reputedly at the suggestion of Nicoladoni. The anastomosis was made on the anterior wall of the stomach. Although von Hacker is credited with the first description of the retrocolic gastrojejunostomy in 1885, it had been reported two years earlier by Courvoisier. In this procedure the anastomosis was made in the posterior wall of the stomach.

Vomiting was so frequent a complication of gastrojejunostomy, a number of modifications were proposed to counteract this. The afferent loop was placed in an isoperistaltic fashion as opposed to the antiperistaltic method first used by Wolfer and the gastroenteric stoma was placed in various positions. Doyen, having noted that the normal position of the duodenojejunal junction was higher than the jejunum, attempted to fix the afferent loop high on the stomach in making an antecolic gastrojejunostomy.

During this time the two most acceptable means of bypassing a high intestinal anastomosis were developed. Braun (1892) described a side-to-side anastomosis between the afferent and efferent loops of the jejunum in addition to the gastrojejunostomy, and Roux (1897) reported on transection of the jejunum with anastomosis of the distal end of the jejunum to the anterior wall of the stomach and the proximal end to the side of the jejunum distal to the gastrojejunostomy, the celebrated Roux-en-Y technique.

Meanwhile Czerny, about the turn of the century, had developed the technique of retrocolic gastrojejunostomy so that the majority of his patients were free of postoperative vomiting. He and his assistant, Petersen, stressed the fact that this was probably due to the extremely short afferent loop, which, of course, did not permit a bypassing enteroenterostomy between the loops. Gradual acceptance of this idea occurred, particularly when it was popularized by such famous surgeons as W. J. Mayo and Sir Moynihan. Thus the short afferent loop, retrocolic

*From the Department of Surgery, University of Kentucky College of Medicine, Lexington, Kentucky

gastrojejunostomy became the standard procedure.

During all of this time the essentials of performing successful gastrointestinal anastomoses were evolved by trial and error. Various unrelenting substances such as bone plates, rawhide plates, the Murphy button and others were gradually replaced by the more supple two-layer technique of an inner absorbable suture to approximate the mucosal edges and an outer non-absorbable stitch uniting the serosal surfaces. Internal hernia, recognized as an occasional complication of the retrocolic anastomosis, was eliminated by suturing the edges of the opening in the transverse mesocolon to the stomach, a technique described by Willy Meyer.

In 1893 Doyen described the successful use of a gastrojejunostomy in a patient with the duodenum obstructed by an ulcer scar. Gastrojejunostomy quickly became the usual means of handling obstructing duodenal ulcer. The technique was employed in patients with chronic, non-obstructive duodenal ulcer and gradually assumed the status of the procedure of choice. It remained in this position for a generation, but an ever-increasing incidence of postoperative marginal ulcer led to reluctant abandonment of the operation.

As dissatisfaction with gastrojejunostomy was developing, von Haberer in Germany and Berg, Lewisohn and Strauss in this country began to employ partial gastric resection for the surgical treatment of chronic duodenal ulcer. Controversy arose regarding re-establishment of gastrointestinal continuity as a gastroduodenostomy (Billroth I) or gastrojejunostomy (Billroth II) and amount of stomach to be resected. The recurrent ulcer incidence of 10-15 per cent following 50 per cent distal gastrectomy, although an improvement over the results of gastrojejunostomy, was not acceptable. This prompted surgeons in the 1930's to increase the reaction. Difficulties with gastroduodenal anastomosis and a higher recurrence of ulcer after Billroth I procedures led to the evaluation of a three-quarter gastrectomy and Billroth II reconstruction as the standard operation for chronic duodenal ulcer. Today it remains the favorite of many surgeons.

Although recurrent ulcer is not a major problem with this approach, it has several disadvantages. The mortality of five per cent or higher is distressing. The incidence of debilitating and sometimes fatal nutritional deficiencies, anemia, specific malabsorption and the dumping syndrome are all too frequent. The additional problems of mechanical defects in the afferent loop further dampened enthusiasm for this procedure.

Dragstedt in 1943 reported on two patients who were relieved of ulcer symptoms by supradiaphragmatic section of the vagus nerves. This approach, although first described by Exner in 1911, was the culmination of many years of physiologic observation of gastric secretory phenomena. However, four years later, Dragstedt recorded the problems of gastric atony and retention in his original two patients and recommended the addition of gastroenterostomy to promote adequate gastric emptying. The remembrance of previous failures of gastroenterostomy as a definitive procedure encouraged many surgeons to oppose vagotomy and gastroenterostomy and favor some type of subtotal gastrectomy.

Wangensteen, a strong advocate of resection, had already shown that a 90 per cent gastric resection cured all patients with duodenal ulcer. Unfortunately, the patient was often a nutritional cripple. After the trial of a "tubular resection", basically similar to the fundusectomy of Connell, was unsuccessful, Wangensteen developed the segmental gastric resection. In this procedure the midportion of stomach containing only acid-secreting mucosa, is removed. A gastrogastrostomy restores continuity, and pyloroplasty may be added or not depending on whether the vagal supply to the pylorus is interrupted. Although this operation is appealing because it does not involve dissection of the "difficult duodenum" and removes only acid producing tissue, the end results in terms of mortality and recurrent ulcer are no better than subtotal resection.

Dragstedt's experimental observations did more than renew interest in vagal section. He and others demonstrated the importance of the antrum in stimulating gastric acid production. Farmer and Smithwick of Boston and Edwards of Nashville independently began to combine vagotomy with a limited distal gastric resection as a surgical approach to duodenal ulcer. This combination removed the two major acid stimulatory mechanisms. Gastrointestinal reconstitution could be accomplished by either gastroduodenostomy or gastrojejunostomy. It became apparent that this procedure was not followed by the debilitation and deficiencies associated with larger gastric resections.

The efficacy of gastroenterostomy in relieving post-vagotomy gastric retention stimulated Weinberg to utilize the Heinke-Mickulicz pyloroplasty as the drainage procedure accompanying truncal vagotomy. His reported operative mortality and end-results have been outstanding. Thus the world of surgery has become divided into two groups—the vagotomists and resectionists.

Current Status

At the present time the controversy regarding definitive surgery for duodenal ulcer disease is as heated as ever. If one disregards the surgeons who are still partial to a three-quarter resection with a Billroth II reconstruction, the current surgical approach to duodenal ulcer disease can be conveniently divided into two groups. The fundamental portion of the operation for either group is parasympathetic denervation of the stomach. The groups divide on what procedure should be used to complement the vagotomy. The vagotomist feels that a simple drainage procedure, usually a pyloroplasty is sufficient; the resectionist advocates extirpation of the antrum in conjunction with the vagotomy. In the absence of a randomized study of patients undergoing surgery for duodenal ulcer, comparison of the results or large

series of patients treated by the two methods will have to suffice for a review of the current picture.

Indications for surgery. The large series of patients who have been subjected to vagotomy and antrectomy show the principal indications for operation as follows: hemorrhage (massive or recurrent), 30 per cent, acute perforation, four per cent; obstruction, 13 per cent, and intractability, 53 per cent. The proponents for vagotomy and pyloroplasty began with a somewhat similar distribution of indications for the surgical management of duodenal ulcer. However, as experience has shown that this is an extremely safe operation, intractability as an indication for surgery has increased steadily. In April, 1969, the University of Florida group reported to the American Surgical Association 455 patients treated with vagotomy and a drainage procedure, predominantly pyloroplasty, and 72 per cent of their patients were operated on for intractability. Several questions arise: 1) Is intractability an indication of less severe ulcer disease which might be expected to respond well to the simpler procedure of vagotomy and pyloroplasy? 2) Because of the safety of vagotomy and pyloroplasty, are patients being offered surgical therapy more often than they would have been when resection was the only technique being employed?

Operative mortality. The operative mortality of vagotomy and pyloroplasty remains quite low, under one per cent in the elective situation. The operative mortality for vagotomy and antrectomy in the elective cases is one per cent and when all cases are considered, that is including emergency surgery, the mortality rate is 2.7 per cent. Probably the one point upon which the vagotomist and resectionist agree is that vagotomy and pyloroplasty as a primary procedure is safer than vagotomy and antrectomy.

Recurrence rate. The recurrence of ulcer disease following vagotomy and antrectomy is extremely low. In the hands of many surgeons it continues to be less than one per cent, and Harkins has concluded that denervation of the stomach combined with antral resection is the most physiologic procedure yet devised for duodenal ulcer disease. The recurrence rate following vagotomy and pyloroplasty is somewhat higher. In Weinberg's hands with adequate followup the recurrence rate was 4.5 per cent, and it has been reported as high as 21 per cent in the patients followed at the University of Kentucky Medical Center. Those who advocate vagotomy and pyloroplasty believe that if the ulcer has not recurred within two years the likelihood of recurrence is low. The enthusiastics for antrectomy combined with vagotomy are just as certain that with long-term followup, recurrent ulcers will continue to appear in patients who have had vagotomy and pyloroplasty as their primary procedure, so that eventually an unacceptable rate will be observed. In fact, some surgeons have expressed the opinion that history may repeat itself. Just as gastroenterostomy eventually was discarded because of a long-term high recurrence rate, vagotomy and pyloroplasty, used routinely in the management of peptic ulcer disease, may also do so.

Postoperative complications. The incidence of postoperative complications is about five per cent in each group. Inadequate nutrition has seldom been a problem following either procedure. Troublesome diarrhea has occurred in one to two per cent of the patients in either group, and another one or two per cent have been bothered by bloating and the problems associated with gastric retention. Anemia has seldom been encountered and long-term deficiencies of calcium have not been reported although it may be too early to be certain about this particular complication.

The Future

Because of the differing etiologic factors and the varied acid secretory pattern in patients with this disease, it seems logical to attempt to select an operation to fit the patients' needs. This is not a new concept. All surgeons presented with the thin individual who has difficulty maintaining weight or the patient who has had pulmonary tuberculosis will choose vagotomy and pyloroplasty as the procedure in the surgical management of duodenal ulcer. Moreover, in England the concept of selective surgery for all patients with ulcer has been promulgated by Orr and Bruce.

The key decision in selecting the proper operation for each patient is what criterion will be used to dictate the operation. At the present time the best measure we have as an indication of severity of disease is the response of the gastric mucosa to maximal histamine stimulation. This has been shown to be an indication of parietal cell mass, the higher the acid output the larger the mass of parietal cells. The British workers have used gastric resection as the standard procedure for duodenal ulcer and have added a vagotomy when the patient has had a high gastric acid output preoperatively. If vagotomy and a drainage procedure is successful for less severe ulcer disease and vagotomy and antrectomy is effective in a majority of these patients regardless of the extent of disease, it seems logical that vagotomy should be the mainstay of selective surgery for duodenal ulcer patients.

At the University of Kentucky Medical Center we are currently evaluating such selective surgery: The patients undergo accurate preoperative secretory studies. A truncal vagotomy is performed in all patients. If the production of HCl is greater than 25 mEq/hour in response to maximum histamine stimulation (given as Histalog^{R} injection), antral resection accompanies the vagotomy.

If the acid production is less than 25 mEq/hour, a simple drainage procedure, usually a pyloroplasty, is utilized in conjunction with the vagal section. This program has been in operation since September, 1965. We have maintained 100 per cent followup on our patients with the help of referring physicians, medi-

cal students and sheriffs, and although it is too early to report results, our known recurrence rate is considerably lower than the 21 per cent we experience with the routine use of vagotomy and a drainage procedure.

Predictions are always dangerous in the field of medicine. However, it would not be surprising if a simpler and more accurate way of determining parietal cell mass may not be forthcoming in the future. If such an accurate assessment can be developed, then selectivity in the operative approach to duodenal ulcer disease may well become the accepted *modus operandi*. Vagotomy will remain as the fundamental procedure and removal of the second major stimulatory mechanism, namely the antrum, will be guided by preoperative assessment of the parietal cell mass.

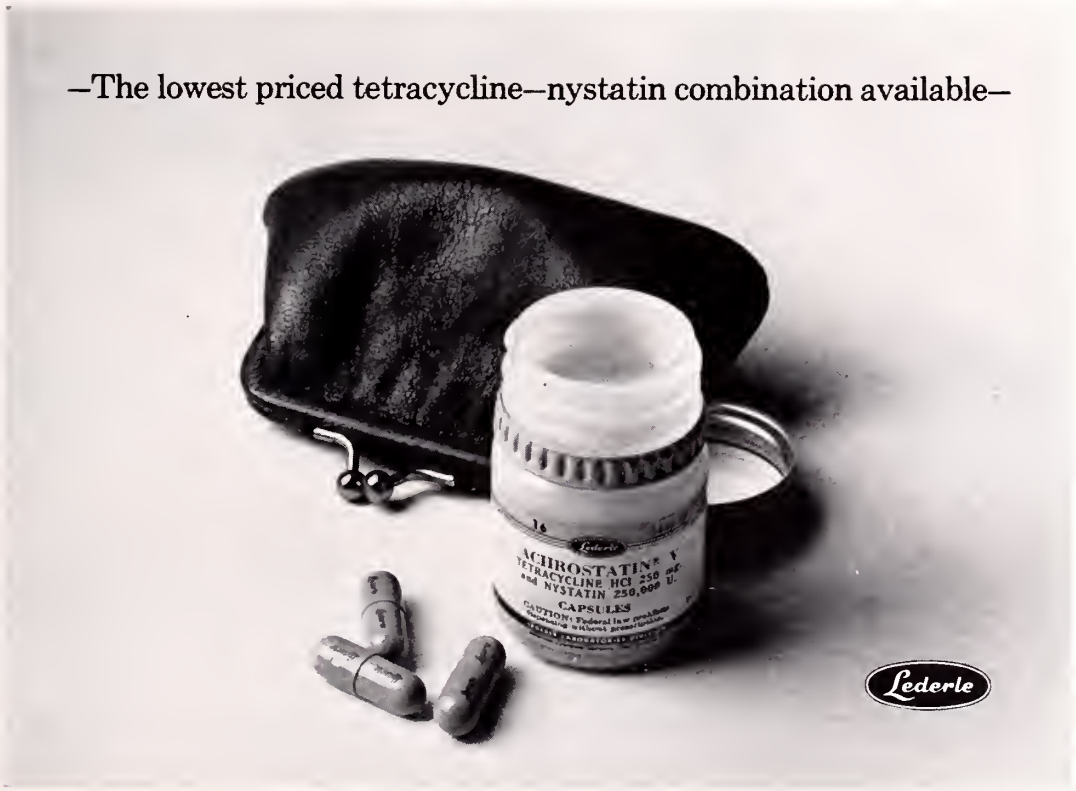
Summary

A brief history of the development of surgery for duodenal ulcer has depicted the rise and fall of gastroenterostomy followed by enthusiasm for gastrectomy. The high mortality rate and complicated courses of patients undergoing resection led to the development of vagotomy and a drainage procedure on one hand and vagotomy and antral resection on the other. At the present time the major controversy regarding surgical management of peptic ulcer disease is based on a preference for one or the other procedures. Vagotomy and pyloroplasty is a safer procedure while vagotomy and antral resection shows the lowest recurrence rate. A prediction is made that vagotomy will remain the fundamental operative procedure and that accompanying antral resection or drainage procedure will depend on an accurate preoperative assessment of parietal cell mass.

Bibliography

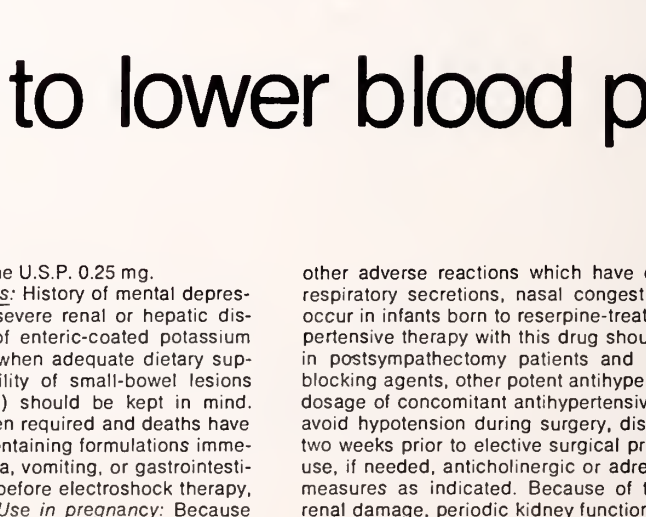
1. Waugh, J. M. and Hood, R. T. Gastric operations: a historic review: I *Quart. Rev. Surg., Obstet. & Gynec. 10*:201, 1953.
2. Waugh, J. M. and Wood, R. T. Gastric operations: a historic review II *Quart. Rev. Surg., Obstet, & Gynec. 11*:1, 1954.
3. Lewisohn, R., Changes in surgical treatment of chronic duodenal ulcers during the past fifty years. *Arch. Surg.* 77:61, 1958.
4. Weinberg, J. A. Pyloroplasty and Vagotomy for duodenal ulcer. Monograph in Current Problems in Surgery, April, 1964.
5. Scott, H. W. Jr., Sawyers, J. L., Gobbel, W. Jr. and Herrington, J. L., Jr. Definitive surgical treatment in duodenal ulcer disease. Monograph in Current Problems in Surgery, October, 1968.

—The lowest priced tetracycline—nystatin combination available—



The Apprehensive Hypertensive



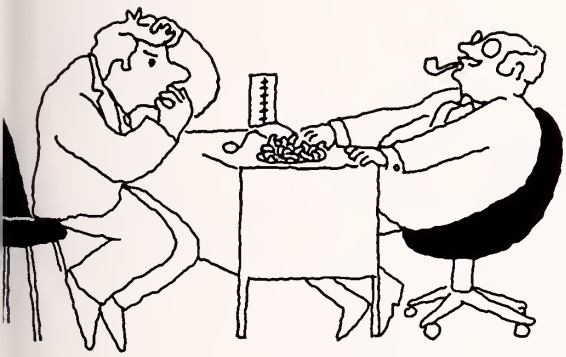


Regroton® to lower blood pressu

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. In respiratory secretions, nasal congestion, cyanosis and anore occur in infants born to reserpine-treated mothers. *Precautions:* pertensive therapy with this drug should always be initiated ca in postsympathectomy patients and in patients receiving ga blocking agents, other potent antihypertensive drugs, or curare. dosage of concomitant antihypertensive agents by at least one- avoid hypotension during surgery, discontinue therapy with thi two weeks prior to elective surgical procedures. In emergency s use, if needed, anticholinergic or adrenergic drugs or other su measures as indicated. Because of the possibility of progres renal damage, periodic kidney function tests are indicated. Disc if the BUN rises or liver dysfunction is aggravated. Hepatic co be precipitated. Electrolyte imbalance, sodium and/or potassi pletion may occur. If potassium depletion should occur during t the drug should be discontinued and potassium supplements provided the patient does not have marked oliguria. Take particul in cirrhosis or severe ischemic heart disease and in patients re

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



WE'VE GOT PROBLEMS.



nd allay anxiety in hypertension

steroids, ACTH, or digitalis. Severe salt restriction is not recom-
l. Use cautiously in patients with ulcerative colitis or gallstones
colic may be precipitated). Bronchial asthma may occur in
ible patients. *Adverse Reactions:* The drug is generally well
d. The most frequent side effects are nausea, gastric irritation,
g, diarrhea, constipation, muscle cramps, headache, dizziness
ite gout. Other potential side effects include angina pectoris,
depression, bradycardia and ectopic cardiac rhythms (espe-
hen used with digitalis), drowsiness, dull sensorium, hypergly-
and glycosuria, hyperuricemia, lassitude, restlessness, transient
impotence or dysuria, orthostatic hypotension which may be
ated when chlorthalidone is combined with alcohol, barbiturates
otics, leukopenia, aplastic anemia, skin rashes, thrombocyto-
agranulocytosis, nasal stuffiness, increased gastric secretions,
are, purpura, urticaria, ecchymosis, weakness, uveitis, optic
and glaucoma, and pruritus. Eruptions and/or flushing of the
reversible paralysis agitans-like syndrome, blurred vision, con-
l injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

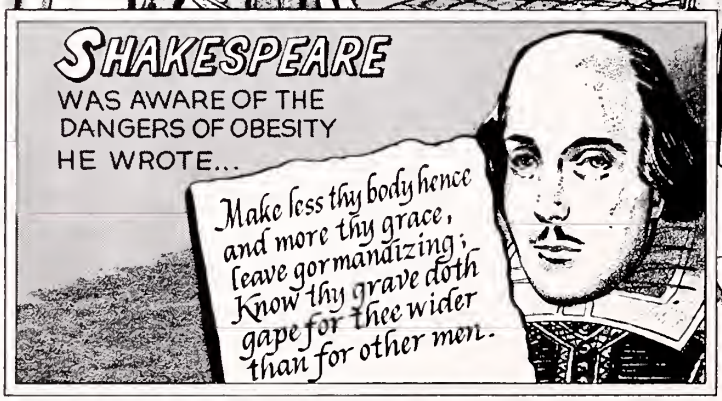
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

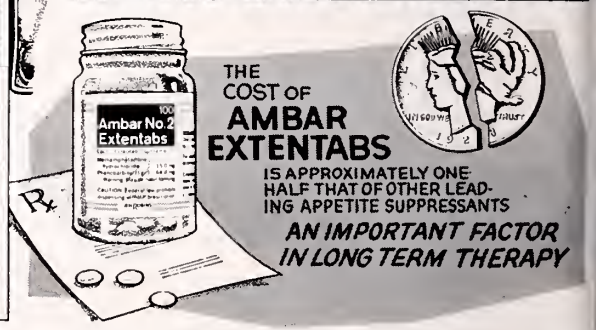


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE

WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





THE COST OF **AMBAR EXTENTABS** IS APPROXIMATELY ONE-HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS

AN IMPORTANT FACTOR IN LONG TERM THERAPY

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS



symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN depressants. As with all CNS-acting drugs, ca tion patients against hazardous occupations r quiring complete mental alertness (*e.g.*, operati machinery, driving). Though physical and ps chological dependence have rarely been report on recommended doses, use caution in a ministering Librium (chlordiazepoxide hydr chloride) to known addiction-prone individu or those who might increase dosage; withdraw symptoms (including convulsions), followi discontinuation of the drug and similar to tho seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potenti benefits be weighed against its possible hazard As with all anticholinergic drugs, an inhibiti effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate limit dosage to smallest effective amount to pr clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tole

or here.



d). Though generally not recommended, if nbination therapy with other psychotropics ms indicated, carefully consider individual rmacologic effects, particularly in use of po- tiating drugs such as MAO inhibitors and enothiazines. Observe usual precautions in sence of impaired renal or hepatic function. adoxical reactions (*e.g.*, excitement, stimula- n and acute rage) have been reported in psy- atric patients. Employ usual precautions in atment of anxiety states with evidence of im- nding depression; suicidal tendencies may be sent and protective measures necessary. Vari- e effects on blood coagulation have been orted very rarely in patients receiving the g and oral anticoagulants; causal relation- p has not been established clinically.

ADVERSE REACTIONS: No side effects or nifestations not seen with either compound ne have been reported with Librax. When ordiazepoxide hydrochloride is used alone, owsiness, ataxia and confusion may occur, ecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

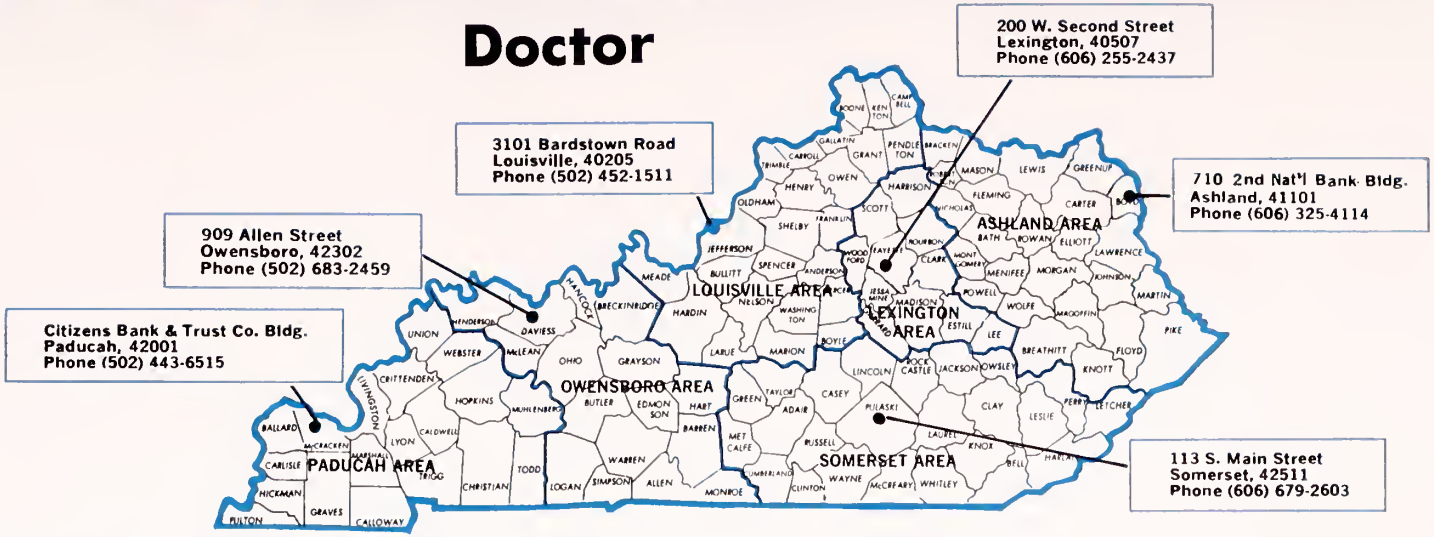
Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

PROFESSIONAL RELATIONS REPRESENTATIVES

At Your Service, Doctor



FROM THESE

6 STRATEGICALLY LOCATED OFFICES . . .

BLUE CROSS® and BLUE SHIELD®' Professional Relations Representatives are available to assist, whenever a physician or one of his staff needs information regarding claims handling, payments, benefits or any other point concerning Voluntary Prepaid Protection.

You are invited to use this special service. FOR ASSISTANCE, please WRITE OR CALL, as shown above, the office located in your area. Your Professional Relations Representative is anxious to serve you.

®'Registered service marks of the National Association of Blue Shield Plans
®Registered service marks of the American Hospital Association

Home Office

BLUE CROSS® and BLUE SHIELD®'

BLUE CROSS HOSPITAL PLAN, INC. KENTUCKY PHYSICIANS MUTUAL, INC.

3101 Bardstown Road Louisville, Ky. 40205 (502) 452-1511

(PLEASE REMOVE THIS PAGE FOR FUTURE REFERENCE)


When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
900541

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 OCTOBER 1969 No. 10

A Report of the Third Annual Kentucky Camp for Diabetic Children

ROBERT E. FRENCH, M.D.* AND NEAL SANDERS, M.D.**

Lexington, Kentucky

In 1968, 50 diabetic boys and girls attended camp near Lexington. No severe insulin reactions occurred, but mild reactions occurred daily and with slightly greater frequency in campers having a lesser degree of glycosuria.

SOON after crystalline insulin became available for clinical use in 1922, Elliott P. Joslin, M.D., and his associates became actively involved in sponsoring camps for diabetic children[1]. Leonard Wendt, M.D., and Franklin B. Peck, M.D., established the first permanent camp near Detroit in 1925[2]. In 1929 the second permanent camp was established near Cleveland by Henry J. John, M.D.[3]. It was named Camp Ho Mita Koda ("Welcome My Friend"). By 1968, 37 annual summer camps had been established in 27 states. Of those states adjoining Kentucky, Ohio has three camps, and Indiana, West Virginia and Tennessee each have one camp. Arkansas does not yet have a diabetic children's camp.

Philosophy regarding the major function of these camps varies. We sent questionnaires to the parents of our 1967 campers. Although most of them felt that the camping experience helped the child learn more about good diabetic management, they also thought that personality development and adjustment were major benefits. The children themselves thought the camping activities and new friends were the best part of the experience. These responses basically agree with the purposes summarized by Etzwiler[4]. These are 1) to provide a camping experience; 2) to improve regulation of the child's condition; 3) to increase the child's knowledge and understanding of diabetes; 4) to promote the child's emotional development.

Our camp opened August 4th at Camp Daniel Boone, the YMCA Camp on the Kentucky River south of Lexington. Fifty diabetic children attended the 12½ day camping session. More than half came from Jefferson and Fayette counties. Six campers were from neighboring states. Their ages ranged from eight to 16. One of the 16-year-old boys served as a junior counselor. The age distribu-

*Department of Internal Medicine, University of Kentucky Medical Center
**Department of Pediatrics, University of Louisville School of Medicine

TABLE I

AGE OF CAMPER	8 yrs.	9 yrs.	10 yrs.	11 yrs.	12 yrs.	13 yrs.	14 yrs.	15 yrs.	16 yrs.
Number of campers:	2	7	6	12	10	5	3	3	2

DURATION OF DIABETES	Less than one yr.	1-2 yrs.	2-3 yrs.	3-5 yrs.	5-10 yrs.	Over 10 yrs.	Total
Number of campers:	4	13	8	11	10	4	50

AGE AT ONSET OF DIABETES	Less than 2 yrs.	2-3 yrs.	4-5 yrs.	6-7 yrs.	8-9 yrs.	10-11 yrs.	12-13 yrs.	14-15 yrs.
Number of campers:	3	5	5	7	13	12	4	1

tion and the age of onset and duration of diabetes are shown in Table 1.

The camp medical staff consisted of one dietitian and an assistant, two registered nurses, and two physicians, one a resident in pediatrics and the other a resident in internal medicine. The non-medical staff included a camp director who was a graduate law student, a camp program director who was also a law student, eight senior counselors who were high school and college students, and several junior counselors who were high school students. Before camp began, all personnel had been instructed in the recognition and treatment of mild hypoglycemic reactions.

When the children arrived at camp our medical staff briefly interviewed the parents and met each camper. Cabin assignments were then made, and the campers began their afternoon routine which consisted of a mid-afternoon snack, organizational activities, and urine testing before supper. Urine checks were again done by the campers under medical supervision prior to the evening snack at 8:30 p.m. Before bedtime we again met with small groups of 12-13 campers and went over the proper procedure for testing urine sugar and acetone until it was ascertained that each camper was familiar with this procedure. At midnight, rounds were made by the two physicians and each camper was awakened.

The first full camping day began when the campers were awakened at 7:15 a.m. During the next hour they double voided, and urine sugar was checked on the second voided specimen. Urine acetone was checked if 3 or 4 plus glycosuria was present. Most of the campers then administered their own insulin injections which had been previously withdrawn by the registered nurses. Most campers who did not want to administer their own injections usually became motivated to do so within a few days when they saw the other children doing it. However, some of the younger children were still too immature to accept this responsibility.

Breakfast was served at 8:15 and the children were off to their morning activities of horseback riding, archery, canoeing, riflery, nature study, swimming, tennis and crafts. Special activities included hikes, cave exploration, a scavenger hunt, a Saturday night dance, skit night, hootenannies, pontoon boat cruises and on the last night of camp, an evening hike to the council fire.

Following the noon meal each day short diabetic discussions were held. The topics included various types of insulin, differences in peak action and duration of action of intermediate and short acting insulins, and the distinction between insulin types and insulin concentrations. In other sessions we discussed factors influencing insulin requirements and attempted to familiarize the campers with the essentials of early recognition and treatment of hypoglycemia, and prevention of ketoacidosis. Individual instruction was given to children who did not know how to withdraw their insulin, and emphasis was placed on the necessity for observing sterile technique, and for continually rechecking the label regarding the type and concentration of insulin. Other days were devoted to discussions of food types and food exchanges. The children were given ample opportunity to ask questions not only during these discussions, but also during in-

formal conversations as the opportunity arose. Emphasis was placed on the importance of establishing regularity in eating, activity and insulin administration, and on their ability to live relatively normal lives when basic requirements of diabetic management were fulfilled. The daily camp routine is outlined below.

Daily Camp Routine

7:15 Arise, void and drink water; wash up; return to cabins and make beds.
7:30 Void and test urine on second voided specimen.
8:00 Insulin injections.
8:15 Breakfast.
9:00-10:15 First activity period. (strenuous)
10:15-10:45 Snack Time (160 calories).
10:45-12:00 Second activity period.
12:00 noon. Void and test urine.
12:30 Lunch time.
1:00-2:00 Quiet hour with diabetic discussion.
2:00-3:00 Third activity period. (strenuous)
3:00-3:30 Snack time (160 calories).
3:30-4:30 Free time with swimming pool open.
4:30 Void and test urine. Supplemental insulin if indicated.
5:00-5:30 Free time for fixing hair, singing, resting, playing etc.
5:30 Supper.
6:30-8:30 Evening camp activity.
8:30 Void and test urine.
8:45 Snack (380 calories).
9:30-10:00 Lights out.
12:00 Midnight check.

Diabetic Management

Insulin dosages on the first camping day were calculated on the basis of what the child had been receiving at home, other relevant history obtained from interviews with the parents, and observations of the two urine checks which were obtained on the day of arrival at camp. In general, the dose was reduced 10 per cent below that which the child had been taking at home. Exceptions were made if the child was spilling acetone or had 3 or 4 plus glycosuria on the day of arrival.

Although we attempted to keep the campers on the same basic insulin regimen which they had been using at home, it proved necessary to make some modifications based on the pattern of glycosuria throughout the day. In many cases smoother control was possible by adding or increasing short acting insulin and by reducing the intermediate or long acting insulin. The average increment in short acting insulins (regular and semilente) was about six units per camper daily and the average decrease in intermediate and long acting insulins (NPH, lente and ultralente) was about five units per camper daily. Unlike many other camps which have reported a significant decrease in insulin usage at camp as compared with the usage at home, our overall change in insulin usage was almost negligible. Actually, rather than decreasing, insulin administration increased minimally, about 1½ units per camper daily by the last three days of camp as compared to the stated dosage just prior to camp. Nevertheless, there were marked individual variations in total insulin dosage change as shown in Table II.

TABLE II

Change in Total Daily Insulin Dose

	(NUMBER OF CAMPERS)		
	Boys	Girls	Combined
Increased 16-20 units	0	1	1
Increased 11-15 units	4	1	5
Increased 6-10 units	3	7	10
Increased 1-5 units	5	3	8
Unchanged	2	2	4
Decreased 1-5 units	7	6	13
Decreased 6-10 units	0	5	5
Decreased 11-15 units	1	2	3
Decreased 16-20 units	0	0	0
Decreased 21-25 units	0	1	1

At the beginning of camp we instructed the camp counselors to report to us all episodes which they felt to be compatible with hypoglycemic episodes, and for which they had given the camper supplemental carbohydrate. Also, at several times during the camping period we asked the campers individually whether they had experienced "insulin reactions". During the 12½ day camping period, 122 such episodes were recorded. None of these required treatment with intravenous glucose, and none of the campers lost consciousness, or convulsed. Glucagon was used in some cases, and oral carbohydrates were given in all cases, usually in the form of

juice, but sometimes as "instant glucose", a viscous glucose preparation.

The incidence of "insulin reactions" can be compared to reports of other camps by converting the figures into a frequency rate expressed as reactions per camper day. Our rate of 0.20 reactions per camper day is similar to the rates reported by other camps and is identical to that reported by Shipp at Florida's Camp Immokalee[5]. Parenthetically, it is interesting that Shipp reported blood sugar values of 50 mg per cent or below on routine determinations in several asymptomatic campers.

We also attempted to document the frequency of ketonuria. Campers were instructed to test their urine with *ketostix* when the urine sugar was greater than 2 plus by the *clinitest* method. Of the 2,556 urine checks recorded, ketonuria was found in five per cent. This is probably an underestimation since ketonuria sometimes occurs when the urine sugar is less than 3 plus. Also, some children occasionally discarded the urine specimen before the urine could be tested for ketone bodies. Both the frequency of ketonuria and the frequency of "insulin reactions" decreased significantly during the latter part of the camping period. The figures are shown in Table III.

Despite daily adjustments of insulin dosage, some campers were never adequately regulated whereas other campers remained stable after their initial ten per cent reduction in dosage. The marked individual variation in the frequency of ketonuria and of "insulin reactions" is shown in Table IV.

We attempted to evaluate some of the factors which might influence diabetic control by classifying each camper into one of four groups depending on the degree and frequency of glycosuria and whether the camper was on a "free diet" or a measured diet. Groups A and B arbitrarily included all campers having 0 to 2 plus glycosuria on greater than 50 per cent of the routine urine checks. Groups C and D arbitrarily included all campers having 3 or 4 plus glycosuria on more than 50 per cent of their routine urine checks. Groups A and C were on measured diets during the major portion of their camping period and groups B and D were on "free diets".

Table V shows the number of campers in each group and some of the other variables which might influence diabetic control. The average age of the campers in the more poorly controlled groups was slightly greater, and the average duration of diabetes was about a year longer than that of campers in the better controlled groups. The campers in the better controlled groups were taking less insulin than those in the more poorly controlled groups, but this difference may be partially related to the predominance of girls, and thus smaller individuals, in the better controlled groups.

A very simple index of diabetic control was calculated for each group by dividing the

TABLE III

		1st Half of Camp.	2nd Half of Camp.	Combined Total
NO. OF "INSULIN REACTIONS".				
	Girls	43	35	78
	Boys	29	15	44
	Combined	72	50	122
NO. OF URINE CHECKS SHOWING KETONURIA.				
	Girls	47	23	70
	Boys	35	19	54
	Combined	82	42	124

TABLE IV

NUMBER OF OCCASIONS DURING THE 12½ DAY CAMPING PERIOD.	"Insulin Reactions"			Ketonuria		
	Boys	Girls	Combined	Boys	Girls	Combined
None	7	3	10	10	11	21
1-2 times	9	13	22	5	7	12
3-5 times	4	8	12	2	6	8
6-10 times	2	3	5	4	2	6
Over ten times	0	1	1	1	2	3
Total Campers	22	28	50	22	28	50

TABLE V

DIET	"Better Controlled" Group A Measured	"Better Controlled" Group B "Free"	"More Poorly Controlled" Group C Measured	"More Poorly Controlled" Group D "Free"	Combined Total
Number of Campers in Group.	22 (44%)	6 (12%)	8 (16%)	14 (28%)	50 Campers
Ratio: Boys/Girls	7/15	3/3	3/5	9/5	22/28
Average Age.	11.3 yrs.	10.3 yrs.	11.5 yrs.	12.4 yrs.	11.5 yrs.
Average Duration of Diabetes.	3 yrs.	4 yrs.	4.5 yrs.	5 yrs.	4 yrs.
Average Daily Insulin Dose.	34.5 units.	30.8 units	42 units.	46 units	38.5 units
Average Change in Daily Insulin Dose, at Camp.	4.5 units less.	1 unit less.	5 units more.	7 units more.	1½ units more.
Index of Control: (Percentage of Urine Checks Showing 0 to 2 plus Glycosuria).					
1st Half of Camp	66%	63%	37%	36%	52.6%
2d Half of Camp	77%	65%	41%	34%	57.7%
Overall Camp Period	71%	64%	39%	35%	55%
Frequency of Acetonuria	2.7%	3.5 %	9%	6.4%	5%
Frequency of "Insulin Reactions" Expressed as "Reactions per Camper Day".					
1st Half of Camp	0.23	0.37	0.12	0.19	0.234
2nd Half of Camp	0.23	0.19	0.18	0.08	0.162
Overall Camp Period	0.23	0.28	0.15	0.14	0.20
Average Prescribed Diet.	2880 Cal./Day	..	2830 Cal./Day	..	..
Average Increase in Diet During Camping Period.	60/Cal./Day.	..	60 Cal./Day	..	..
Deviation from Average Weight, (Based on Height).	0.4% above.	1% above.	0.6% above.	1% below.	Norm

number of urine checks showing 0 to 2 plus glycosuria by the total number of urine checks. Campers who were on measured diets had an index of control of 62.5 per cent as compared to an index of 43.5 per cent for the campers on "free diets". The frequency of "insulin reactions" was also slightly higher for campers on measured diets.

Discussion

Observations of various factors influencing diabetic regulation among the 50 campers at the 1968 Kentucky Camp for Diabetic Children clearly demonstrate the expected inverse relationship between decreased glycosuria and the frequency of "insulin reactions". Nevertheless, over the 12½ day camping period the index of diabetic control for the camp as a whole increased by about five per cent without an increase in the frequency of "insulin reactions". Reactions in fact decreased by about 0.07 reactions per camper day. We attributed this tendency toward better overall regulation partially to the identification of campers who required significant changes in their total insulin doses. Also, in part, this tendency was probably related to the general reduction in the dosages of intermediate and long acting insulins and to the general increase in the dosages of the shorter acting insulins.

Although the frequency of "insulin reactions" among the girl campers was higher than

among the boys, this difference may have been partially artifactual since there were almost twice as many girls in the better controlled groups than in the more poorly controlled groups.

Better diabetic control appeared to be positively correlated with campers who received measured diets. Seventy per cent of the campers on measured diets were in the better controlled groups, as compared to only 30 per cent of those who were on "free diets". The possibility that more severely diabetic children may have predominated in the groups of campers receiving "free diets" cannot be excluded, however.

It appears significant that campers on "free diets" had a decreased frequency of "insulin reactions" during the second half of the camping period although there was not any significant improvement in the degree of glycosuria. By comparison, campers on measured diets showed a tendency toward better diabetic control in terms of decreased glycosuria, but the frequency of "insulin reactions" did not diminish during the second half of the camping period.

Looking at the camp as a whole, optimum regulation appeared to coincide with an index of control of about 57 or 58 per cent on any given day. Above this level, the frequency of "insulin reactions" tended to rise above the norm of ten per day. Figure 1 illustrates this graphically.

We hope that these observations of our 1968 campers will help provide a baseline for future attempts to identify specific factors which will allow more rapid adjustments of insulin dosages for diabetic campers as they are suddenly confronted with changes in activity, diet and their whole pattern of living during the camping period.

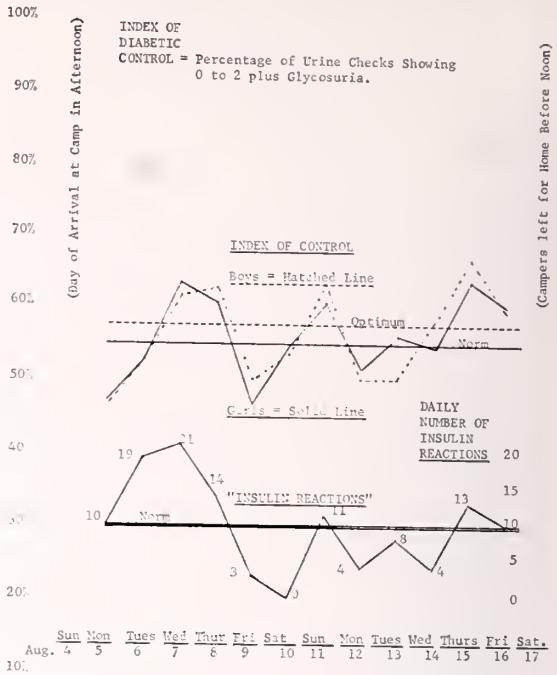


FIGURE I

References

1) Marble, Alexander: Summer Camps for Diabetic Children, *Diabetes*, 1:245-251, May-June, 1952.
2) Wendt, Leonard F.C. and Peck, Franklin B.: The Summer Camp as a Factor in Control of Diabetic Children, *JAMA*, 96:1217-1219, April 11, 1931.
3) John, Henry J.: The Planning of a Camp for Diabetic Children, *Am. J. Med*, 1:642-648, December, 1946.
4) Etzwiler, Donnell D., Drummond, Keith R., Medina, Ambrosio M., Youngquist, Ronald B., and Siemers, Dorothy E.: Wilderness Camping for the Diabetic, *Diabetes*, 14:676-681, October, 1965.
5) Shipp, Joseph C.: A Florida Summer Camp for Diabetic Children, *JAMA*, 184:312-314, April 27, 1963.

Deaths in a Small Community Hospital

ROMEO S. BERARDI, M.D.* AND MARY A. HALL. M.D.**

McDowell, Kentucky

This article details a study of all deaths occurring in a four and one-half year period in a small community hospital. Its importance is underlined from an educational, clinical, administrative and planning point of view.

IT IS not customary for one to embark upon a study of deaths occurring in any given hospital, much less for one to be willing to submit such data for publication. However, from an objective point of view, much can be learned and taught from such a detailed review.

Although it had been common practice for hospitals to speak of net death rate, which excludes deaths occurring during the first 48 hours after admission, it is becoming clear that such a policy no longer has any meaningful significance. As a matter of fact, it is being realized that one of the most effective ways of determining whether the hospital and its medical staff are deliverinng the latest and best of medical knowledge, is precisely by studying those deaths which occur within 48 hours of admission.

The magnitude of the problem of early hospital deaths becomes evident when one considers that approximately 25 per cent of 60,000 patients who died in 1963 in 294 hospitals did so during the first or second day of hospitalization. These hospitals had more than 2,400,000 admissions during the same year and are considered fairly representative of short-term general hospitals in the United States and Canada[1].

Since July, 1966, all deaths occurring in the McDowell Appalachian Regional Hospital have been thoroughly presented and discussed at its monthly mortality meeting. This attitude was unanimously adopted by the medical staff for it was realized that such a policy could only result in improved care and diagnosis. Including early hospital deaths only added to our conviction. This approach has also gradually brought forth fruitful improvements and needs for our hospital. Granted that not all requested improvements have been met because of financial considerations, the medical staff has found itself in a position to assign significant priorities to its recommendations which are being progressively realized. The educational benefits derived from such presentations are evident.

The McDowell Appalachian Regional Hospital is a 60 bed institution located in the southeastern part of Kentucky. It is staffed by eight physicians, three general physicians and five specialists, three of whom are board certified. The hospital has an approved affiliate surgical residency program and an approved clinical cancer program. Since its opening in 1956, three-year approvals have consistently been received from the Joint Commission on Accreditations of the American Medical Association.

This study covers the period of July, 1964 to January, 1969, and includes all deaths occurring in the hospital. The purpose is to underscore its importance from an educational, clinical, administrative and planning point of view.

Clinical Material and Data

During this study period, 9402 patients were admitted to the hospital, 2405 operations were performed and 183 deaths occurred including newborns.

Of the 183 deaths, 16 or 8.7 per cent were considered operative, that is, occurring within a 30 day period following operation, giving a

*Chief of Surgery, Appalachian Regional Hospital, McDowell, Kentucky
**Family physician, ARH, McDowell, Kentucky

mortality rate of 0.64 per cent. This is well within the predictable national average of 17 per thousand operated patients for short-term general hospitals[2].

Thirty-eight or 20.7 per cent of the total deaths were terminal cancer patients. Some terminal cancer patients are cared for in the hospital for reasons which will be elaborated upon later. In spite of this policy our hospital stay per patient has averaged about six days over the past four and one-half years.

There were 65 early deaths (within 48 hours), accounting for 35.5 per cent of the total as compared to 118 or 64.5 per cent late deaths (after 48 hours). Fifty or 73.8 per cent of the early deaths occurred within 24 hours of admission.

Of the early deaths 47 were males and 18 females, giving a male/female ratio of 2.6:1. The median age was 52.5 years with a range from the newborn to 89 years. The following represents the age distribution for the early death group:

0-1 years	13
1-10	2
10-20	1
20-30	0
30-40	2
40-50	2
50-60	14
60-70	6
70-80	13
80-	12
Total	65

Of the late deaths 76 were males and 42 females, giving a male/female ratio of 1.8:1. This group had a median age of 63.1 years, ranging from the newborn to 100 years. The age distribution for this group is as follows:

0-1 years	1
1-10	1
10-20	0
20-30	1
30-40	5
40-50	5
50-60	24
60-70	30
70-80	33
80-90	16
90-	2
Total	118

The causes of early deaths are given below. Although many had significant contributing causes, only what was believed to be the primary cause was ascertained from each case. When a pathologic diagnosis was available, the primary cause of death was obtained from this report.

Myocardial Infarction	15
Congestive Heart Failure	8
Prematurity (Newborn)	8
Trauma	8
Terminal Malignancy	7
Cerebral Thrombosis	5
Bronchopneumonia/Pneumonia	2
Pulmonary Embolism	2
Cerebral Hemorrhage (non-traumatic)	2
Meningitis	2
Respiratory Failure	2
Aspiration	2
Exanguination	1
Gastroenteritis	1
Total	65

In the late group the causes of death were as follows:

Terminal Malignancy	31
Congestive Heart Failure	19
Cerebral Thrombosis	16
Myocardial Infarction	15
Bronchopneumonia/Pneumonia	14
Pulmonary Embolism	7
Cerebral Hemorrhage (non-traumatic)	3
Trauma	2
Respiratory Failure	2
Peritonitis	2
Septicemia	2
Hepatic Coma	1
Burns	1
Malignant Hypertension	1
Prematurity (Newborn)	1
Aspiration	1
Total	118

The length of stay in the late death group averaged 14.7 days with a range of three to 120 days. Three patients remained in the hospital over 100 days, nine between 30 and 100 days and the remainder less than 30 days.

In both groups 62 or 33.8 per cent of the total had the benefit of consultation. Thirty-five autopsies were obtained giving a rate of 19 per cent. Clinical diagnoses coincided with anatomical diagnoses in 74.2 per cent of the cases.

Discussion

A study of deaths provides material for many important considerations. In this study 27.3 per cent of all deaths occurred within 48 hours of admission. Six of these were either so critically injured or ill that death ensued within one hour after arrival to the emergency room. Although this percentage appears to be somewhat higher than the 25 per cent figure alluded to above, it must be noted that of the total group of deaths, 38 or 20.7 per cent were terminal cancer patients. In any event,

it does point out the necessity of maintaining a readied, adequately equipped and well staffed emergency room.

Of the 16 operative deaths, three resulted from severe forms of trauma to the head, one from a massive crush injury to the abdomen and pelvis with internal bleeding and four had a non-resectable cancer with metastases. Two were considered purely anesthetic, one occurring after an uneventful operation and the other during induction. The over-all operative mortality rate was 0.64 per cent, well within the 17 per thousand operated patient range cited above.

It might be asked why terminal cancer patients are admitted to the hospital for what amounts simply to nursing care? Our area has a very limited number of good nursing homes; most people in this area are convinced that such patients are the primary responsibility of the physician; home care is for the most part unavailable; the medical staff feels that it is much better to have such patients die in the hospital rather than to leave them with people who are not only incapable of rendering terminal care but who for the most part have no desire to do so. This policy has not increased the average patient's hospital stay, being about 6 days during this study period.

As can be noted from the age distribution of both groups, the overwhelming majority of patients were above 50 years, 30 being over 80 years old. This characterizes our general hospital population which consists of a good proportion of geriatric patients.

This study conclusively proves the conviction that intensive coronary units are a necessity in small community hospitals. Thirty patients in either group died primarily from myocardial infarction. This was either shown at autopsy or by electrocardiography. It is the decided opinion of the medical staff of this hospital that cardiac monitoring devices would salvage a substantial number of these patients and would certainly add effectively to the over-all care of the coronary patient.

Infant deaths were included in this study in order to determine foreseeable and feasible means of performing better in the care of these infants. Of the 14 deaths in this category, nine were premature, two having congenital anomalies incompatible with life. All nine died within three days. Of the remaining four, two died as a result of meningitis and two from severe head injuries secondary to trauma. The infant death rates in Kentucky have shown improvement, from a rate of 28.6 infant deaths per 1000 live births in 1957 to 24.1 in 1967[3]. The infant death rate in this hospital was 14 in 1045 live births during this four and one-half year period. The necessity of continued improvement and competent nursery personnel is realized.

The multiple injured patient in small community hospitals is as much a responsibility as in larger centers. These are precisely those patients who require immediacy and accuracy of treatment. Well organized, equipped and staffed emergency rooms ready to assume this increasing demand are mandatory.

Aspiration accounted for three deaths, two early and one late. Although it occurred in debilitated patients, it is the feeling of our nursing staff that it can be further decreased. This is being assumed as a nursing responsibility. Up-dating methods and continued instruction are most important.

The low autopsy rate in this study most certainly must be increased. The greater majority of autopsies are obtained by the more permanent members of the staff, whereas those physicians who are more or less transient have contributed very little in this regard.

Appropriate and immediate consultations in the various specialties remain a problem in small community hospitals, since the greater majority are not represented on the active staff. Whenever such consultations are available, results are decidedly improved.

We are not dwelling on the illusion that all deaths are preventable. What is most important, however, is that our performance be periodically reassessed in order to improve upon the care delivered to these patients and thereby to all patients in general.

Conclusions

A study of all deaths in a four and one-half year period occurring in a small community hospital was reviewed. Pertinent data have been presented and discussed. It is suggested that such studies be carried out in all small community hospitals. Its value is quite apparent from an educational, clinical, administrative and planning point of view.

(Continued on Page 781)

Subarachnoid Hemorrhage: A Physician's Guide To Diagnosis and Treatment

H. Martin Blacker, M.D., Horace A. Norrell, Jr., M.D. and Charles B. Wilson, M.D.*

Lexington, Kentucky

Bleeding into the subarachnoid space most likely signals the presence of an intracranial aneurysm. This analysis emphasizes simple techniques of diagnosis and outlines the results of treatment based on 100 consecutive cases.

THE SUDDEN escape of blood into the cerebrospinal fluid produces a characteristic clinical picture. Often subarachnoid hemorrhage (SAH) signals the presence of a potentially curable lesion. The curability of this lesion depends on the state of the patient after the hemorrhage, as well as proper timing and selection of neurosurgical treatment.

The family physician is a key link in this therapeutic chain for it is he who must recognize the condition and initiate treatment. An analysis of 100 consecutive cases of subarachnoid hemorrhage encountered at the University of Kentucky Medical Center is presented to emphasize some principles of management.

Diagnosis

The diagnosis of subarachnoid hemorrhage is based upon the history, symptoms and signs associated with the presence of blood in cerebrospinal fluid.

The symptoms and/or signs fall into two categories:

(1) *Signs and symptoms related to the irritation of the meninges due to the presence of blood in cerebrospinal fluid.* The meningeal irritation most commonly produces a dramatic sudden headache, which may be generalized, retro-orbital or suboccipital. The headache is most often described as being unlike anything the patient has experienced before, and may be shortly followed by unconsciousness or drowsiness, confusion and photophobia. A common associated finding is nuchal rigidity which results from reflex contraction of the cervical muscles secondary to meningeal irritation.

(2) *Local involvement of one part of the nervous system.* Examples of this type of clinical manifestation include: (a) hemiparesis from an intracerebral rupture of a middle cerebral aneurysm and (b) oculomotor palsy secondary to third nerve compression by an aneurysm near the origin of the posterior communicating artery, etc. These will be dealt with more fully when the individual categories of lesions are discussed.

Lumbar Puncture

The most important procedure in confirming diagnosis of a subarachnoid hemorrhage is the lumbar puncture. Pitfalls await the physician even after the lumbar puncture needle is properly positioned. Attention to detail in analysis of the fluid is imperative.

The most dependable indicator of spontaneous subarachnoid hemorrhage is the occurrence of xanthochromia of the supernatant fluid after the blood CSF is centrifuged. Faint xanthochromia may be detectable only when the supernatant is compared against the same background with clear water placed in the same type of vial containing the CSF. Xanthochromia is due to the pigment bilirubin converted from the breakdown of hemoglobin released from damaged red cells. The exact time after the bleed when xanthochromia first appears is uncertain, but most authorities agree that it takes about four hours from the

*All from the Division of Neurosurgery, University of Kentucky Medical Center, Lexington, Kentucky

moment of subarachnoid hemorrhage; therefore, it is essential that the CSF specimen be centrifuged immediately after it is obtained, since red cells will continue to break down in the tube. Other commonly employed techniques used to differentiate a traumatic tap from a spontaneous subarachnoid hemorrhage—such as lack of clearing of bloody CSF when collected in three tubes, and the presence of red cell crenation—are unreliable. While the clearing phenomenon does tend to indicate that the tap was traumatic, the lack of clearing does NOT rule out a traumatic tap. Red cell crenation appears immediately after blood is mixed with spinal fluid when the tap is traumatic, hence this finding is of no value in establishing a diagnosis.

The opening pressure is usually elevated, frequently over 350 mm of CSF. There is no place for bilateral jugular compression (Queckenstedt test), and its performance in individuals with increased intracranial pressures may precipitate a caudal shift of intracranial structures threatening the patient's life.

Further Management and Treatment

Further management and treatment depend on the patient's state of consciousness, presence or absence of a focal neurological deficit, and the presence of associated illness, (e.g. severe pulmonary or hypertensive cardiovascular disease). Based upon the patient's condition (Table I) a clinical class is assigned[1]. The system arose from the observation that early operation in patients with aneurysms who were alert or had a negligible neurological deficit was successful whereas operations upon patients with a marked deficit or in coma was associated with a high mortality.

The timing of angiography and management is indicated in Table II.

TABLE I

(Modified after Botterell[1])

Classification of Patients with Subarachnoid Hemorrhage

Grade	State of Consciousness	Meningeal Irritation	Hemiparesis
I	alert	absent or mild	absent
II	alert	mild to moderate	abent or mild
III	drowsy and/or	moderate or severe	moderate or severe
IV V	stuporous and/or comatose		decerebrate

Note: The patient advances one grade (e.g. from II to III) with any one or two of the following findings: severe diabetes, established hypertension (diastolic greater than 110 mm Hg), severe pulmonary disease, severe cardiac or other peripheral vascular disease, marked obesity, age 65 or over, other major medical problem (e.g. liver disease).

TABLE II

Timing of Angiography and Operation According to Patient Classification

Grade	Timing of Angiogram and Operation
I & II	Early angiography and operation
III	Early angiography and manage conservatively until grade I or II is reached unless there is evidence of a rebleed without advance in grade or there are angiographic signs of a hematoma
IV & V	Conservative management. Patients are not candidates for operation.

Etiology of Subarachnoid Hemorrhage

The etiology of subarachnoid hemorrhage in our series of 100 cases is depicted in Table III. This series reflects the main conclusions of others[2,5,6,7], namely, that the vast majority of subarachnoid hemorrhage is attributable to ruptured aneurysms of the arteries at the base of the brain.

TABLE III

Etiology of SAH in 100 Consecutive Cases at the University of Kentucky

Etiology	Number of Cases
Aneurysm	66
A/V Malformation	11
Etiology Undetermined	23
Total	100

If the patient's condition permits (Table IV), early angiography is performed within 24-48 hours after the patient's arrival in the hospital. The risk of carotid and vertebral arteriography with present technology is minimal. In our series there were no deaths attributable to angiography and only two had permanent sequelae (Table V).

Angiography was performed in 96 cases with cerebral aneurysm demonstrated in 66 cases and AV malformation in 11 cases. In 19 cases angiography did not disclose the cause of the hemorrhage. Sixteen of the 19 patients with normal angiograms had total angiography; the remaining three had bilateral carotid angiograms only and thus a lesion in

TABLE IV

Complicating Illnesses

100 patients (Subarachnoid Hemorrhage)

	Aneurysm	A-V	Etiology Undetermined
Hypertension	9	0	3
Diabetes	2	0	2

the posterior intracranial circulation was not excluded.

Four cases, because of failing vital signs, were deemed too critical for the study. Three of these four patients whose condition was too critical died and no autopsy was performed.

Other possible causes of subarachnoid hemorrhage are tumors, blood dyscrasias and infections[2,6]. Although, in the U.K. series, no such lesions were disclosed.

TABLE V

Complications of Angiography

96 cases

Permanent hemiplegia	1
Permanent quadriplegia	1
Transient paresis	2

Aneurysms

Since the vast majority of SAH is attributable to a ruptured cerebral aneurysm, this group will be discussed in detail.

The mean age of our 66 patients with SAH from aneurysm was 45, with a range depicted in Table VI.

The mortality of ruptured cerebral aneurysm managed conservatively is high. Walton[2] reports a mortality rate of 40-50 per cent within the first eight weeks of the initial hemorrhage. Of these, about two-thirds die from the effects of the first hemorrhage, often within the first 24 hours; the remaining one-third will die from a second hemorrhage usually within the second week after the initial SAH. This underscores the compelling need for early diagnosis and proper neurosurgical management directed toward avoiding a second hemorrhage. According to Walton about 20 per cent will die of subsequent hemorrhage from six months to several years. Of the long term survivors, only one-third are symptom-free. Walton concludes: "Although the indications are not yet absolutely clear, it is now apparent that the prognosis of the condition (cerebral aneurysm) can be radically improved by the judicious application of surgical methods of treatment."[2]

In weighing conservative management versus operative treatment of cerebral aneurysm, we must first separate that group of patients who are moribund from the initial hemorrhage from those who survive its effects, since operations on patients in coma from SAH are almost always fatal. Meaningful mortality and morbidity figures on the natural history of SAH from aneurysm are difficult to gather, resulting partly from inadequate follow-up. A large population group in the same region carefully followed for up to ten years was compiled by Pakarinen[5]. He makes an effort to correct the figures which would be distorted by the fact that the more seriously ill patients do not receive operations. His corrected mortality figures for patients with aneurysms who survived the first hemorrhage but who died from subsequent hemorrhages is 63 per cent for the first year and 72 per cent within the first five years.

TABLE VI

Ages of 66 Patients with Aneurysms

Age	Number
10-19	1
20-29	8
30-39	8
40-49	20
50-59	24
60-67	5
MEAN AGE	45

Our series contains 66 patients with aneurysm. Seventeen of these were severely obtunded or comatose (grade 3 or 4) (Table I & II) and thus were not candidates for operation. All died within the period of the first hospitalization. Fifty-three operations were carried out on the remaining 49 patients with a mortality of 12.2 per cent. Another six patients sustained an increased neurological deficit. The remainder of the complications are listed in Table VIII. Multiple intracranial aneurysms occurred in 12 patients, an incidence of 18 per cent corresponding to the figure reported in other series. Posterior fossa aneurysms were found in ten cases or 16 per cent demonstrating the necessity of vertebral angiography in all patients.

TABLE VII

Class of 17 Patients with Aneurysm Dying Before Operation

Class 3	4 Patients
Class 4	13 Patients

A/V Malformations

Eleven patients had A/V malformations. Most were found in the first two decades of life (Table IX). There were two deaths, one in a patient not operated upon, the other died following surgery. Seven had excision of the malformation with no sequelae. An additional patient was treated conservatively and remains normal. Our incidence of A/V malformations of 11 per cent of all cases of SAH is higher than that of most series which range between two and six per cent[5, 7]. Generally, follow-up study of A/V malformations reveals a low mortality rate. Yet, in the Finnish series (which contained few A/V malformations) one out of six patients died of recurrent hemorrhage[5].

TABLE VIII

Complications of Operations Aneurysms (531)

	Number of Cases	Percent
Deaths	6	12.2
Wound Infections	2	20
Increased Neurological Deficit (permanent)	6	
Post-op Edema		
Bone Removed	1	
Seizures	1	
Hydrocephalus, Requiring Shunting	1	

SAH With Normal Angiography

In this group the prognosis is generally regarded as good. In the Finnish series the patients were followed for an average of just under five years[5]. Only two patients (3.6 per cent) died of recurrent hemorrhage. In our series, all 19 patients in whom angiography was performed without demonstrating the cause of hemorrhage, survived the period of hospitalization and were discharged essentially normal. The period of follow-up is too short to permit any conclusions concerning their recurrence of SAH.

Pathology

The sudden introduction of blood into the subarachnoid space causes rapid elevation of intracranial pressure, which if extreme, may of itself produce unconsciousness. This, associated with systemic hypertension may be confused with hypertensive encephalopathy. The fever, leukocytosis, and meningismus reflect the irritation of the meninges by blood and its breakdown products.

TABLE IX

Age of 11 Patients with A/V Malformations

Age	Number
1-9	1
10-19	5
20-29	1
30-39	1
40-49	2
50-59	1

One immediate effect of blood in the subarachnoid space is that the CSF pathway becomes compromised and thus communicating hydrocephalus is frequently produced[8]. This probably results from a mechanical interference of flow of CSF with plugging of the basal cisterns and arachnoid villi. Usually the red cells will disappear from CSF by the ninth day, although the range is four to twenty days and sometimes longer. There is great variation in the ability to clear the CSF blood from patient to patient[4]. Protein elevation persists for three to four weeks.

Arterial Aneurysms

Saccular aneurysms are small outpouchings on the walls of the cerebral arteries. The distribution of aneurysms in our series is depicted in Table X. More than 80 per cent are distributed on three vessels: anterior-cerebral-anterior communicating complex, internal carotid, and middle cerebral arteries. In most series, about 20 per cent of aneurysms are multiple and about 15 per cent originate from the vertebral and basilar arteries.

TABLE X

Location of 81 Aneurysms (66 Patients)

Internal Carotoid	33
Anterior Cerebral-Anterior Communicating	20
Middle Cerebral	19
Basilar-Vertebral	9

Several factors are thought to contribute to the development and subsequent rupture of an aneurysm:

1) A defect in the media of the arterial wall is thought to contribute to aneurysm formation. The size of the defect, rather than its mere presence, influences the development of an aneurysm. They occur commonly at sites of branching of the arteries.

2) Systemic arterial pressure is an important contributing factor since its presence accelerates cerebral atherosclerosis (a wall-weakening process).

3) Atherosclerosis of the parent vessel may further weaken the mural defect. The aneurysm usually ruptures through the thinned fundus, rarely near the neck. An important point in the development of the clinical picture and the prognosis of a hemorrhage is the fact that some aneurysms tend to rupture into the substance of the brain, rather than into the subarachnoid space. This intracerebral rupture may lacerate and track extensively into the brain producing an irreversible damage.

Three to seven per cent of aneurysms may have a significant subdural clot whose aspiration may improve the patient's chances for survival.

Summary

SAH is a dramatic event which usually produces sudden severe headaches with signs of meningeal irritation. Correct diagnosis is the most important step in the management and depends upon the careful performance of spinal puncture. All patients with bloody cerebrospinal fluid should receive neurosurgical evaluation.

Most often SAH signals the presence of a cerebral aneurysm which, although potentially lethal, is often curable by judicious operative treatment.

The mortality with surgical treatment in this series was 12 per cent, considerably below the mortality which results from expectant non-operative treatment. The mortality of non-operative treatment of ruptured cerebral aneurysm in the patients who survive the initial hemorrhage is over 60 per cent[5].

Bibliography

1. Botterell, E.H., Lougheed, W.M., Scott, J.W., and Vandewater, S.L.: Hypothermia, and Interruption of Carotid or Carotid and Vertebral Circulation in the Surgical Management of Intracranial Aneurysms. *J. Neurosurg.*, 13:1-42, 1956.
2. Walton, J.N.: *Subarachnoid Hemorrhage* (Edinburgh, Livingstone, 1956).
3. Walton, J.N.: *Essentials of Neurology,* Philadelphia, J.B. Lippincott, pp. 304 ff.
4. Tourtellotte, W.W., Simpson, B.J., Metz, L.N., and Bryan, E.R.: Intracranial Hemorrhage and Cerebrospinal Fluid, Chapter V, *Intracranial Aneurysms and Subarachnoid Hemorrhage,* Ed. W.S. Fields, A.L. Sahs, Springfield, C.C. Thomas 1965.
5. Pakarinen, S.: Incidence, Aetiology, and Prognosis of Primary Subarachnoid Hemorrhage. *Acta Neurol. Scand.,* Supp. 29, 43:1-128, 1967.
6. Locksley, H.B.: Natural History of Subarachnoid Hemorrhage, Intracranial Aneurysms and Arteriovenous Malformations. *J. Neurosurg.,* 25:219-239, 1966.
7. Intracranial Aneurysms and Subarachnoid Hemorrhage, A Cooperative Study. Ed. Sahs, A.L., Perrot, G., Locksley, H. and Nishoha, H., J.B. Lippincott, 1969.
8. Foltz, E., Discussion p. 433, *Pathogenesis and Treatment of Cerebrovascular Disease.* Ed. by Fields, Wm. J., C.C. Thomas Publ., Springfield, Ill., 1961.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Let's be specific about Campbell's Soups... and *reducing diets*





There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Pro-Banthine® Helps...

propantheline bromide

...REVEAL the ulcer

...HEAL the ulcer

The efficiency of Pro-Banthine—its favorable balance of therapeutic and secondary actions—has been thoroughly tested and observed. This quality has been demonstrated surgically, roentgenographically, cinegastroscopically and, above all, clinically.

When physicians needed to relax the restless duodenum for the recently refined technic of hypotonic duodenography they logically turned to Pro-Banthine.

For years Pro-Banthine has been the most widely used anticholinergic medication for calming the gastrointestinal tract—for suppressing secretion, prolonging the action of antacids and providing the proper environment for healing peptic ulcers.

These established therapeutic actions make Pro-Banthine particularly useful in:

- peptic ulcer
- gastritis
- diverticulitis
- irritable colon
- biliary dyskinesia
- functional hypermotility

We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

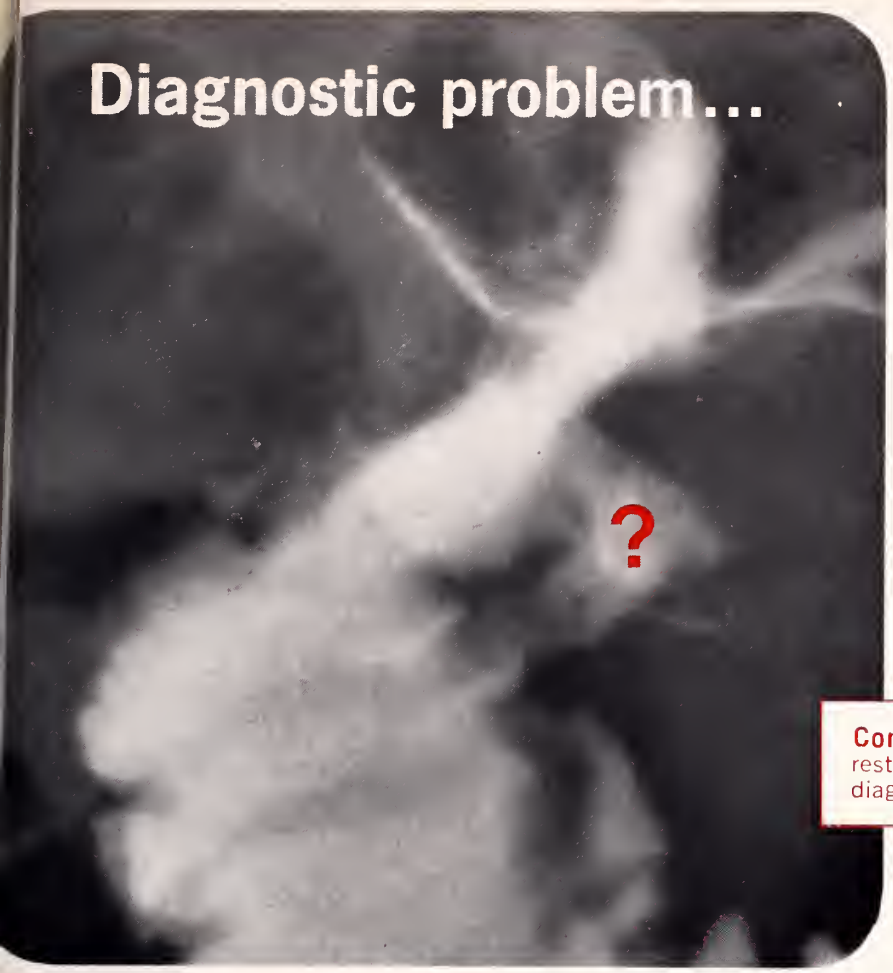
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal dosage tolerated without excessive side effects is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two 15-mg. tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

982

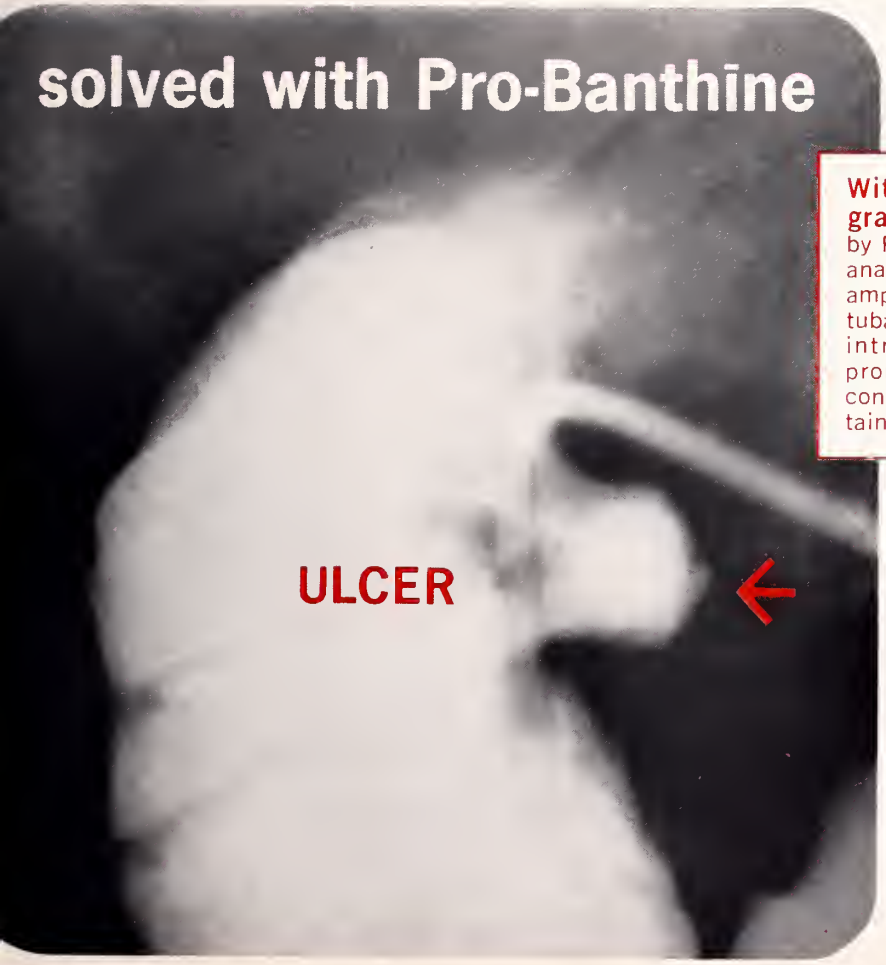
SEARLE *Research in the Service of Medicine*

Diagnostic problem...



Conventional x-rays of the restless duodenum are often diagnostically indefinite.

solved with Pro-Banthine



With hypotonic duodenography duodenal calm induced by Pro-Banthine permits clear anatomic appraisal. In this example the duodenum was intubated. Pro-Banthine, 60 mg. intramuscularly, produced prompt aperistalsis. Double contrast visualization was obtained with barium and air.

What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

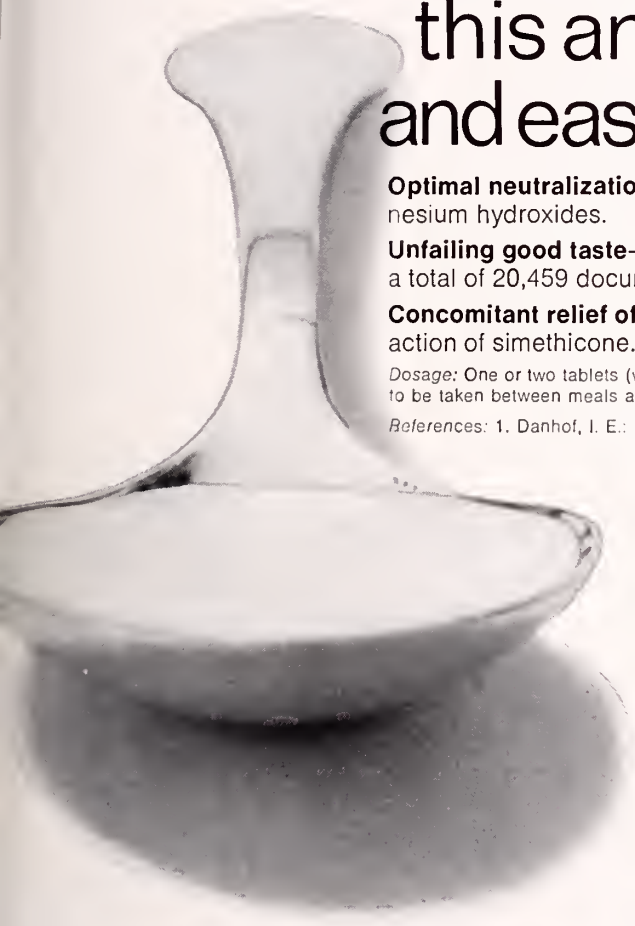
And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

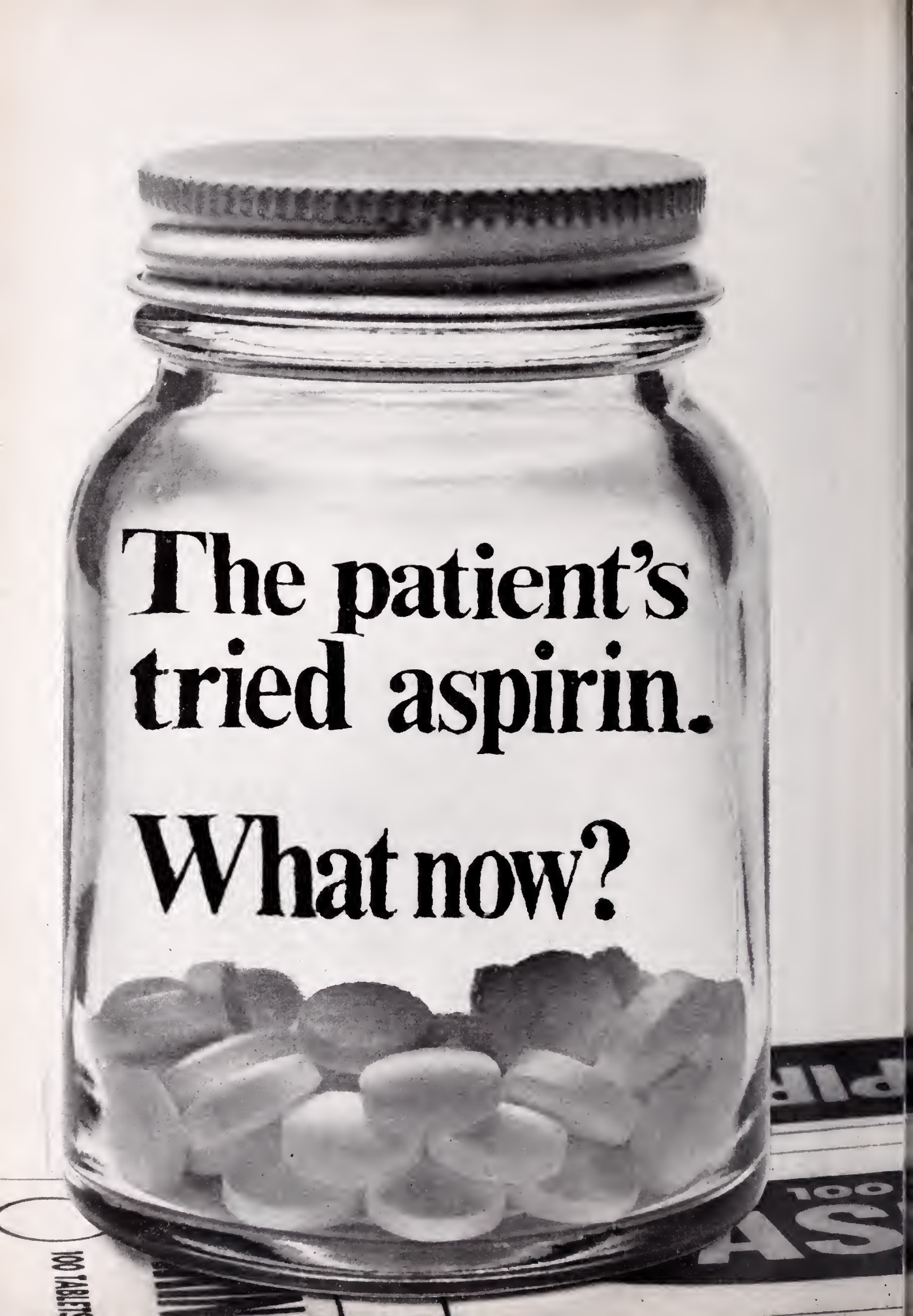
Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109


The patient's
tried aspirin.
What now?

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

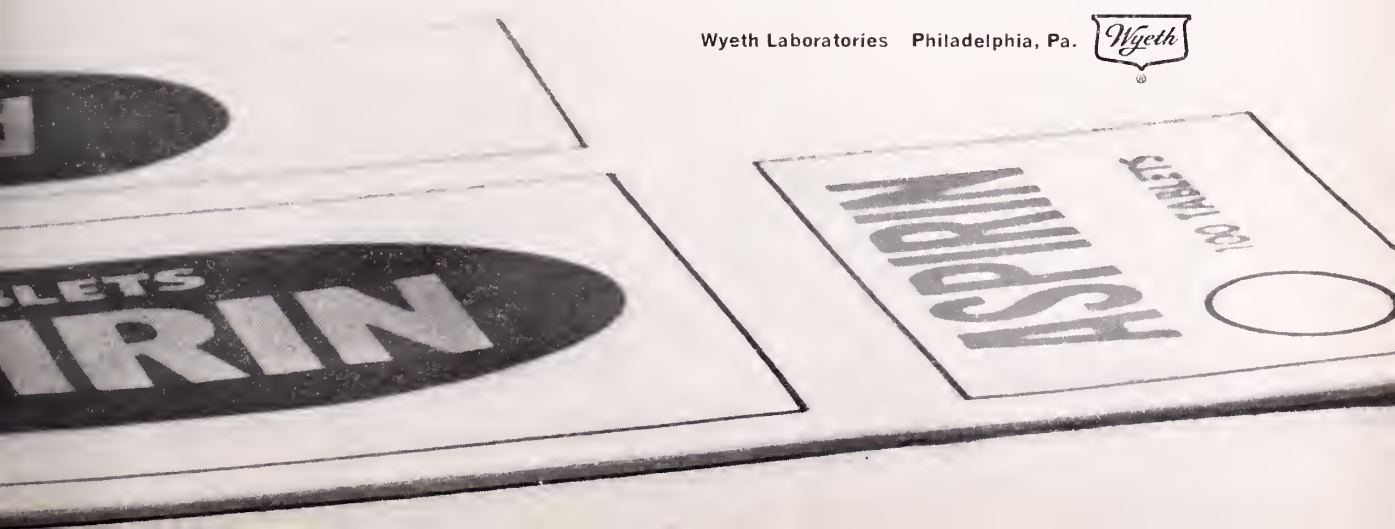
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



SPECIAL ARTICLES

Presidential Address*

HENRY B. ASMAN, M.D.

ONE year ago the highest honor that is within your power to bestow upon one of your fellow physicians came to me when I assumed the Presidency of the Kentucky Medical Association.

In accepting that honor I attempted to express my gratitude to you for it, my humility at being placed in the company of some of the great men of Kentucky medicine who have preceded me in this office, and recognized the awsome task that lay ahead. Since then, I have endeavored to discuss with you, from time to time, in the Journal and in other communications, some of the challenges which, in my opinion, were of critical interest to our Association at the moment.

This has been a busy, eventful and rewarding twelve months. I cannot say, in truth, that success has crowned our every effort, though I believe it has been a good year. There has been a sense of deep frustration and disappointment when the accomplishment of some goals seemed to grow more and more impossible of attainment as my term of office neared its end.

During this year I have traveled many thousands of miles to represent KMA at state, regional and national meetings, and have spent hundreds of hours meeting with our peers in medicine, representatives of allied professions and para-medical groups, government officials, and the public. As your official spokesman, I have always endeavored, with the advice and guidance of the Board of Trustees, to express what I believed to be the wishes of the majority of our members.

These hours of meetings, and the research, study and thought necessary to understand and discuss the tremendously varied subjects under consideration, have truly provided an education for me. Rather than basing opinions on heresay, on newspaper stories, magazine articles, or private communications from less than reliable sources, it has been necessary to make an in-depth study of problems from varied points of view in order to develop an objective position in the best interest of the profession and the public.

During the course of this educational process I must admit that there has been a change in some of my personal views in regard to the responsibilities of medicine in the 1970's. Some of these I hope to discuss with you this morning, though I hasten to assure you that I have not become a "liberal," nor have I forsaken my long-standing opposition to socialized medicine, compulsory health insurance, or whatever name you wish to give it.

In this connection, it is interesting to note that the current promoters of such plans — Mr. Walter Reuther's Committee of 100, which unfortunately includes our own Senator Cooper — while decrying the high cost of health care (brought about, in no small measure, by Medicare and Medicaid) proposes government medical care for the entire population. It is not difficult to recognize from their statements that their primary purpose is to bring the medical profession under the control of the government, based on the politically attractive premise that only in this way can everyone be guaranteed their right to quality health care — at bargain prices.

I submit to Mr. Reuther and his supporters that the health of this nation is intimately and inseparably involved with the problems of housing, sanitation, environment, nutrition, education, and all the other factors affecting our lives. Though we are deeply concerned with these problems, they are not the primary responsibility of the medical profession. The best of medical care will not guarantee good health to the unfortunate, malnourished individual living in sub-standard housing with poor sanitation. Despite the innumerable programs and the massive expenditure of tax dollars in these areas, the government has not yet been able to solve the problems; can we expect health programs to be the answer!

Communication between KMA and its members continues to be a problem of major concern. I was most honored this year to have been invited to each of the 15 Trustee districts. After attending 14 of these meetings I was forced to miss the last one because of the critical illness of my grandson. The special slide presentation prepared for these meetings was an attempt to bring the story of KMA to its members. Approximately 15 per cent of the mem-

* *Delivered September 23, 1969, Louisville, Kentucky.*

bership, with their wives in most instances, attended these meetings and I would like to think that they are a little better acquainted with the functioning of their Association.

But — what about the other 85 per cent? Some of them unquestionably are quite knowledgeable and are active participants in organized medicine, both on the county and state level. Without doubt, however, thare are still a great many who do not attend meetings, do not read the Journal, ignore the Communicator and any other communication on a KMA letterhead, yet are influenced, and attempt to influence others, with opinions based on heresay, emotional statements and provincial prejudices, and totally lacking in objectivity.

Without questioning for one moment the sincerity of these individuals, I renew my plea that they devote the time and the effort to consider, with an open mind, all of the facts, as well as the consequences — present and future — of the policies we adopt. Now is not the time for KMA to stand still! We must give evidence to ourselves and to the public that we can change, that we can progress, that we can meet the demands of the 70's, and persist in our determination to provide the best possible medical care to all of the citizens of this Commonwealth. No longer can we reject new ideas simply because "we've never done it that way before"!

We have given evidence of our deep interest in the health of Kentucky by the leadership our members have demonstrated in the development of Area Comprehensive Health Planning Councils. There has been activity in each of the 15 areas, thanks to the interest of our Trustees under the stimulation of KMA's Committee on Comprehensive Health Planning. Knowledgeable physicians have recognized the opportunity presented by this program and have devoted untold hours to it. Their efforts will be rewarded in the years to come when Kentuckians will benefit from sensible, well-organized, economically sound programs and facilities, and improved methods of delivery of health services.

Our measure of success has been somewhat less in the area of Medicaid and Medicare. The primary fault with the Medicaid program is the law itself. Poorly conceived, hastily prepared, and passed without public hearings by the 89th Congress, Title XIX promised free and practically unlimited medical care to an indeterminate number of people. It is an open invitation to abuse by both providers and beneficiaries. It has pauperized many states which had neither the resources, facilities, personnel or know-how to administer it.

Even some members of Congress will now concede that it is a poor law, but, practically in the same breath, attempt to point the finger of blame for its failure toward the medical profession by publicly making an issue of the number of physicians who received more than $25,000 from these programs in one year, and suggesting that they be audited by the Internal Revenue Service. This they justify on the basis of proven fraud on the part of a minute number of providers, only a few of whom held an M.D. degree. The implication of wrong-doing by the profession is there, and unjustly so, especially when it comes from a body which had just recently voted itself, and other Federal employees, a 2.5 billion dollar a year raise.

It has become popular in recent months for some politicians and bureaucrats to attempt to justify their accusations by proclaiming that "doctors generate the bulk of Medicaid expenditures," and that, therefore, we are primarily responsible for its cost. Resorting to the same use of semantics, we could say that rescue and relief agencies, and the construction industry, generate the major cost of a disaster.

Rescue and relief agencies exist to cope with a disaster, such as the recent hurricane, and the construction industry repairs or replaces the damaged homes and businesses. Physicians exist to cope with accidents and disease, which generate the bulk of Medicaid expenditures in the same way that a disaster generates the major cost of rescue, relief and reconstruction.

In each instance, use is made of the skills, tools and mechanisms developed to fight their particular foe, and the price tags on those resources generally are established in the market-place by others than those who use them.

As reflected in a statement recently sent to the Senate Finance Committee, we do not believe that Title XIX can be "amended" into a good law, but recommended that Congress rescind this portion of P.L. 89-97, and, after careful study and expert advice, develop a sound, workable program that is both fiscally and administratively feasible — for the benefit of the needy and medically needy of the country.

We would further recommend that some of our Congressmen, the bureaucrats, and members of the "fourth estate" spend one day of their vacation with a physician in eastern Kentucky — or any other underprivileged area — and then decide whether or not they believe that a gross reimbursement of $25,000, or even $50,000, per year represents excessive compensation or justifies a threat of harassment by the IRS.

Any discussion of Title XIX must take notice of the subtle efforts of the local news media to implant in the minds of its readers the idea that Medicaid is "the brainchild of the AMA" and that, therefore, the physicians should stop complaining about it and assume the major responsibility for controlling its cost. Although they have never spelled out the basis for the statement that medicine "thought up" this program, it must be presumed that it results from AMA's backing of the old Kerr-Mills law as a mechanism to provide medical care to the needy. The media know that there is no real relationship between Kerr-Mills and Title XIX, either in scope or implementation, but only in principle, and that the AMA not only did not propose Medicaid, but did not even have an opportunity to express its opinion of it since the law was passed without public hearings. This is one more attempt in a continuing effort to discredit organized medicine in the eyes of the public.

Here at home, the Kentucky Medical Assistance Program continues to muddle along in an entirely unsatisfactory manner. Even some in Frankfort admit that one of the major faults lies, not in abuse or over-utilization, but in the administration of the program — as the result of the dual responsibility of two government agencies.

KMA leadership has attempted to work closely with the Administration on these problems. We believe that most of the people in Frankfort, who are involved in Medicaid, are sincerely interested in making the program work — just as we are — and I am hopeful that the answer will soon be found. Early in this year we recommended to the Governor that the administration of Medicaid be transferred by contract to an organization in the private sector with the facilities, personnel and experience to execute a program of such massive proportions. This, we still believe, should be the ultimate answer.

Governor Louie Nunn has repeatedly voiced his concern that the Medicaid program in Kentucky will cost about 50 million dollars in the next fiscal year. This is a tremendous sum of money for one of the poorer states, even when the Federal government puts up 75 per cent of it. But, because Kentucky is one of the poorer states, there are about 250,000 citizens eligible for Title XIX benefits, and simple arithmetic shows that this amounts to about $200 per year per person for medical and dental services, hospital and nursing home care, and drugs. It has been pointed out to the Administration, too, that the physicians continue to subsidize this program in Kentucky since the Legislature refused in 1968 to budget for all in-hospital physician services, as had been promised. It is to be hoped that the next Legislature will correct this inequity.

Our concern for the impact of Medicaid on the budget for the next biennium is tempered somewhat when we read in the news media that the Kentucky Education Association's preliminary budget request for the next Legislature calls for an *increase* of 190 million dollars in the appropriation for education.

Here in Kentucky we, too, have witnessed great publicity given to a few physicians who have received large sums of money for services rendered Title XIX recipients. A very few of these have been subjected to investigation and, though the results of those investigations have not been made public, none as of this date have been accused of crime or been indicted.

I will repeat here what I have attempted to make crystal clear to the press: KMA will not be put into a position of defending any physician who has been proven guilty of breaking the law or of a breach of medical ethics, but we will, likewise, not be willing to see a physician convicted in the press or in public opinion on the basis of a large gross reimbursement unless he has been presented with the evidence against him and had an opportunity to defend himself, and until he has been proven guilty.

There is no question in the minds of any of us that the vast majority of physicians in Kentucky are honestly endeavoring to render needed service to the public and, in order to do so, are working longer hours and under greater strain than most any other segment of the population. These are the factors — not financial considerations — that contribute to the continued shortage of physicians in the rural areas of our state.

Medicare in Kentucky has been less of a problem although the action of Wilbur Cohen, before he left office as Secretary of HEW, has resulted in the pegging of physician's fees at the level of January, 1969. In the face of continuing rise in the cost of living, in taxes and in overhead, this seems unrealistic especially in view of the fact that no other segment of the working public appears willing to forego its regular increase in compensation.

Discussion of these governmental programs leads naturally to another subject, in which medicine has been interested for years, but which has been thrown into the spotlight in recent months as a result of questions concerning possible over-utilization or abuse of these programs. I refer, of course, to Utilization Review or Peer Review, or whatever name you may give it.

We have grown accustomed to Claims Review— where a committee of our peers will pass judgment on the reasonableness of our claim submitted to a third party, or upon the fairness of a third party in handling a claim submitted by us. Utilization Review, however, implies more than just a consideration of fees, and involves, in fact, quality control of the practice of medicine. A moments reasoned reflection convinces one that the two cannot be separated.

Medicine has always proclaimed its determination to provide the best possible medical care to its patients. We have exercised some measure of control over quality in our hospitals — through the mechanism of staff privileges — but how about the out-of-hospital practice? Utilization Review most emphatically does not imply the presence of a "policeman" constantly looking over our shoulder during office hours. But — the mere presence of a mechanism for such review will serve as an ever-present reminder of our obligation to practice quality medicine. Can we justify the repeated doses of an antibiotic for an acute upper respiratory infection? Does a complaint of "heartburn" demand an x-ray study of the entire G.I. tract in every instance? Is it really necessary to visit the elderly stroke victim in the nursing home three times a week? Are all of those B-12 shots medically indicated?

These are examples of the questions which we must be prepared to answer. It is much better that we answer them to ourselves, rather than to an agency outside the profession.

In a report to the AMA House of Delgates in July, the Council on Medical Service concluded that it "knows of no greater challenge facing the profession today then to secure universal acceptance and application of the review concept as the most meaningful method of creating a public awareness of medicine's efforts to assure high quality of health services at a reasonable cost, slowing the rate of escalation in health care charges, stimulating health insurance organizations to make broader protection

available to more people, and retaining professional control in patient-physician fiscal and economic relationships."

It is incumbent upon KMA, in my opinion, to broaden the perspectives of the Claims Review mechanism established last September by the House of Delegates, and assign to it the responsibility of developing the guidelines and procedures necessary to permit KMA to take the lead in Utilization Review. Other medical groups of the nation have undertaken this duty years ago. If we wish to maintain control of the practice of medicine in our state, we would do well to follow their example without delay, profiting by their experience and advice.

If we are to effectively implement medical review it will unquestionable be necessary to involve a great many more of our members in this effort to assure quality medical care for all — with the added dividend of increasing the participation of the members in the constructive projects or organized medicine.

Hand-in-hand with Utilization Review goes medical education — and more especially continuing medical education. With the tremendous explosion of medical knowledge in recent years, it is not easy for the busy practitioner to remain abreast of the times, And yet, if we do not practice modern medicine we defeat the whole purpose of organized medicine — and our failure will be spotlighted by the review mechanism.

KMA must continue to exert its best efforts toward this goal. Inevitably, much of the responsibility for continuing medical education must fall upon our two medical schools. Although one might protest that the schools are already pursuing this field, I would suggest that much more can be done— new approaches must be tried, older methods, tried and proven in other areas, must be adopted. It is difficult to understand the apparent reluctance on the part of our schools to promote the concept of affiliation with interested private hospitals in the Commonwealth for the training of interns and residents.

There is little doubt that the stimulus of a training program improves the caliber of medicine in a community hospital which accepts the challenge of such an undertaking, and the resulting academic environment reflects itself upon the medical staff. There is at the present time, I believe, only one private hospital in the state with fully approved internship and residency programs, without university affiliation, and these are maintained at great expense to the hospital and its patients in recognition of its responsibility in the field of continuing medical education. Several other hospitals apparently have partial, or departmental, affiliations which are of limited value to the staff or medical community.

Our record of performance in this area is not an enviable one. The Commonwealth of Kentucky expands a sizeable sum of tax dollars each year in support of our two medical schools, the majority of whose students are Kentucky residents. Far too many of these individuals, upon graduation, are unable to pursue their training in Kentucky hospitals and consequently leave the state — all too often never to return. And the acute shortage of physicians in Kentucky goes on! We have lost not only our investment in their education but have, more importantly, lost their badly needed medical talents.

Anyone who has had contact with recent graduates of the two medical schools must realize that our universities are producing intelligent, well-educated physicians. Evidence is also available, I am told, that this present breed of students and recent graduates are more interested in involvement in the care of patient's needs than in "ivory tower" medicine. If this be so, there is an added incentive for the universities to take the initiative in promoting programs of post-graduate training for these young physicians in community hospitals. In the area of patient care — this is "where the action is"!

There is further and encouraging evidence that medical students today are becoming more interested in the personal care of patients. I am not referring to the small minority of students who gain the headlines with their desire to destroy organized medicine and the system of medical practice as we know it — but have nothing constructive to offer in its place. I refer to the sincere, intelligent young men and women whose views are reflected in a statement made to me recently by a senior student at a large mid-western medical school. He said "I intend to practice medicine for a living when I get out. Yet, in three years of medical school, I have had no exposure to the private practice of medicine, nor have I even met a physician in private practice — except on my own initiative in my home town during vacation."

I am convinced that a large percentage of the students want to meet us, would like to associate with us more freely, to learn what the private practice of medicine is all about, and to learn the reasons behind the positions and policies of organized medicine. If not from us, from whom will they learn? Certainly not from the press, nor the Student Health Organization, nor even from other physicians who, themselves, have never been in private practice nor participated in organized medicine.

I believe, too, that we can learn from the students. Medicine is not a static profession. Radical ideas of a few decades ago are now accepted as commonplace. Fresh ideas, though they may seem radical today, will stimulate us to continued growth and dynamic progress. After all, these young men and women will be the leaders of medicine in just a few short years.

Recent steps taken by the Jefferson County Medical Society to stimulate student memberships are most encouraging. The mechanism is being developed whereby students will participate in floor discussions and in committee work of the Society and receive all society communications. They would pay minimal dues but, since they do not yet hold the degree of doctor of medicine, they could not become active, voting members. Opening this avenue of communication between organized medicine and

(Continued on Page 784)

DOCTOR!

You are cordially invited to attend

KENTUCKY THORACIC SOCIETY'S FALL CONFERENCE ON RESPIRATORY DISEASES

November 7 and 8

Boone Tavern Hotel—Berea, Kentucky

FRIDAY, NOVEMBER 7

6:30 p.m. **Dinner**

"TB Versus the Commonwealth"
State Senator, Clyde W. Middleton
Chairman, Comprehensive Health Planning Council

SATURDAY, NOVEMBER 8

Richard B. McElvein, M.D., Presiding Officer

8:30- 8:45 a.m. **"The Case Against BCG"**
Michael L. Furcolow, M.D.
Professor of Epidemiology
Department of Community Medicine
University of Kentucky Medical Center

8:45- 9:00 a.m. **"The Case for BCG"**
H. Mac Vandiviere, M.D.
Professor of Community Medicine
University of Kentucky Medical Center

9:00- 9:30 a.m. **"TB Control and Case Finding"**
Jerry Brimberry, Public Health Advisor
Tuberculosis Control Program
State Department of Health
Frankfort

9:30-10:00 a.m. **"Preventive Treatment For TB"**
Vernon N. Houk, M.D., Deputy Chief
Tuberculosis Branch
National Communicable Disease Center
Atlanta, Georgia

10:00-10:30 a.m. **"Problem of TB in Kentucky Today"**
George Brockman, M.D., Chairman
Tuberculosis Study Committee
Greenville

10:30-11:00 a.m. **Coffee Break**

Robert L. Rice, M.D., Presiding Officer

11:00-11:30 a.m. **"Can Lungs Be Transplanted?"**
David Blumenstock, M.D.
Mary Imogene Bassett Hospital
Cooperstown, N.Y.

11:30-12:00 Noon **"Why Lungs Cannot Be Transplanted"**
Paul Stevens, M.D.
Director, Pulmonary Laboratory
Methodist Hospital
Houston, Texas

12:00-12:30 p.m. **"Miner's Lung"**
Robert Penman, M.D., Associate Professor
Director, Pulmonary Disease Section
Department of Medicine
University of Kentucky Medical Center

12:30- 1:00 p.m. **"Tobacco and the State and Federal Governments"**
Charles Fagan
Depnty Secretary of Commerce
Washington, D.C.

KENTUCKY THORACIC SOCIETY · 1954 ·

® NTRDA

Program acceptable for 4 Elective hours by the American Academy of General Practice



introducing alginates to antacids

for a difference in taste you can feel

Derived from seaweed, and long used to impart velvety consistency to foods, alginates—a Warner-Chilcott contribution to antacid palatability—help 1) erase the chalkiness and grittiness found with some other antacids; 2) dispel unpleasant aftertaste. Like ice cream, Gelusil-M is smooth and creamy; and it has a cool mint flavor. Thus, for your patients Gelusil-M is excellent to start on and easy to stay on.

introducing

GELUSIL®-M

NEW

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patien



Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-91-4C

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully intregated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

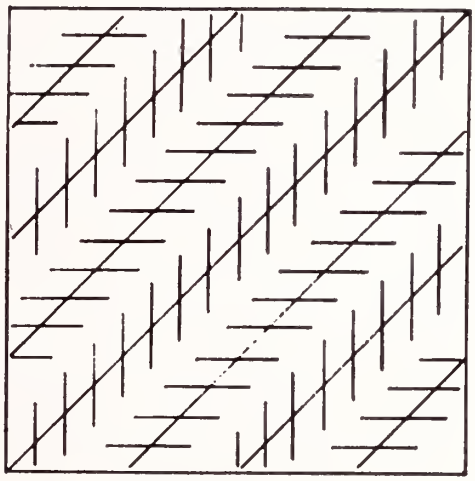
Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green



The New Physician

During the spring of this year leaders of the student body at the University of Louisville School of Medicine approached officers of the Jefferson County Medical Society with the question as to whether a more meaningful student membership could be established in the Society. As a result of a meeting between student leaders and society officers, an ad hoc student liaison committee was appointed. Subsequent recommendations by this committee led to a new type of student membership in the county society. This was referred to in the Presidential Address of Henry B. Asman, M.D., made at the time of the KMA Annual Convention in September.

The new student membership allows for freedom of the floor in all discussions, membership on committees, attendance at the monthly dinner meetings—at reduced rates—and the receiving of all publications of the Jefferson County Medical Society. This new type of membership does not include voting privileges. It was the opinion of the Board of Governors of the Society that the right to vote was an earned one—a right that was earned primarily by successfully completing medical school. There are at the present time many examples in medicine where full voting membership is only achieved after successfully completing certain professional requirements.

The students who have led in the discussions with the Jefferson County Medical Society are officers of the University of Louisville Chapter of the Student American Medical Association. These students have expressed the desire to learn more about how organized medicine works—and to learn more about the problems that the county and state medical society encounters. The students have also expressed the desire to have greater contact during the medical school period with private practitioners of medicine. It is their anticipation that being active in the county medical society will help to provide this contact.

The national organization of the Student American Medical Association was founded in 1950 and now has a membership of 24,000 medical students in 87 different medical schools. The stated purposes of the Association are to improve medical education, to contribute to the improvement of health care of all people, and to involve its members in the social, moral and ethical obligations of the profession of medicine. The Association publishes a monthly journal—*The New Physician*—which is mailed to more than 50,000 active and affiliate members of the organization. The SAMA has also been active in the political and legislative fields. Recently, the president of SAMA appeared before the House Appropriation Subcommittee on Labor, Education and Welfare to support the organization position on federal loans to medical students.

Another national medical student organization has received much publicity this past year—unfavorable publicity insofar as the average practicing physician views it. This is the Student Health Organization, which is approximately four years old—and made up of some 2,000 medical students, nurses, social workers and others. It was this organization which participated in the interruption of the annual AMA meeting this past spring. A number of other organizations, such as Medical Committee for Human Rights, Movement for a Democratic Society, Health Policy Ad-

visory Center, Rockefeller University Committee for a Democratic Society and others, took part in that particular demonstration. It is apparently the desire of the SHO to change the present health-care system—not so much by evolution and reform—but by revolution. This is not the case with the SAMA. Its members wish to join the present medical establishment—first, to learn and then to help in the solution of the problems in the health-care field. Its leaders are energetic, articulate, and have proven leadership capabilities. It would be anticipated that the present leaders of the students will eventually become leaders in organized medicine. Their membership in the Jefferson County Medical Society should prove of value to them—and to the Society.

WALTER S. COE, M.D.

The S.M.A. in Atlanta

IF YOU received and read the Southern Medical Association's latest bulletin you must be all aflame with an urge to visit Atlanta in November when the S.M.A. convenes there the 10th to the 13th for the annual convention. Atlanta is progressing so rapidly that to have seen it four years ago is inadequate. Even then it was fantastic—now it is more so.

Kentucky is one of the smaller of the 17 states comprising the S.M.A. membership, but it has had a very significant share in its growth and development during the 66 years of its operation. A. Clayton McCarty, M.D. was the latest president from our state. J. Duffy Hancock, M.D., was, until last year, a trustee, and Andrew Moore, of Lexington, is our present councilor.

The 21 specialty sections will provide an abundance of new information of sufficient variety to satisfy the desire of anyone, even the most discriminating. The smaller discussion groups and the opportunity for participation is a feature particularly attractive to all. The hospitality and good fellowship which always prevails is most gratifying.

Recreation and evening entertainment cannot be excelled, and rarely equalled, in any of our cities. You should go, but you should also take your wife. She, too, will enjoy Atlanta.

SAM A. OVERSTREET, M.D.

See November Issue

for Complete Coverage of

1969 Annual Meeting



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

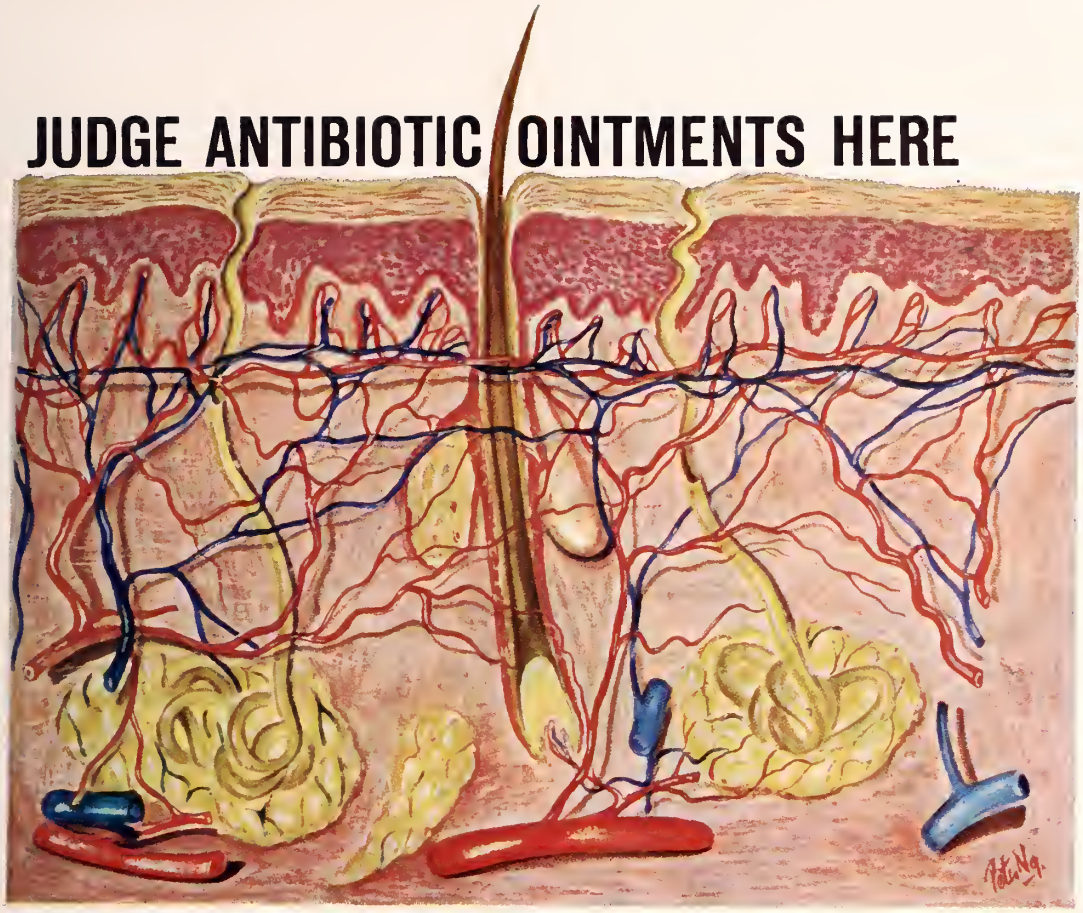
Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

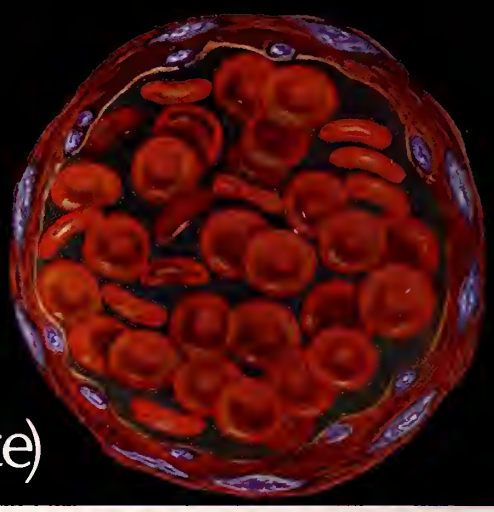
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



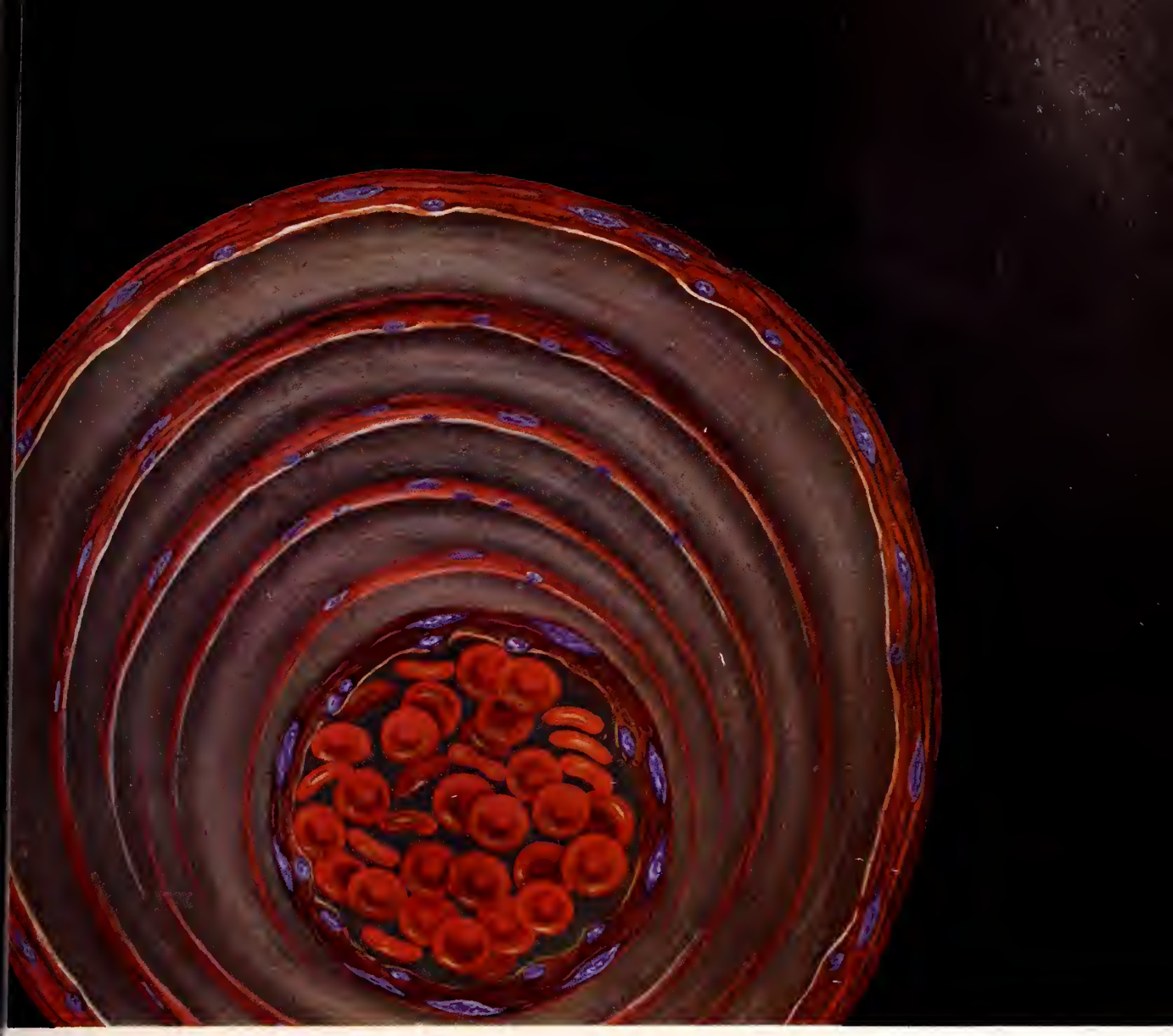
Because peripheral vasodilation is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided by sustained-release Roniacol Timespan (nicotinyl alcohol tartrate) Tablets. Part of the drug becomes available immediately, the remainder continuously over a period of up to 12 hours, and dilation of constricted peripheral vessels is usually maintained. Thus, with a single dose of medication, patients can enjoy the benefits of increased peripheral blood flow in ischemic extremities for up to 12 hours.



ıooth peripheral vasodilation from initial sage...extended with ıple, well-tolerated, b.i.d. dosage

olonged action of Roniacol Timespan inyl alcohol tartrate) together with its benefits offer a therapeutically practical ire in the long-term management of ıeral vascular disease–advantages ally important for older patients.

e prescribing, please consult complete ct information, a summary of which /s:

ıtions: Conditions associated with ent circulation; e.g., peripheral vascular e, vascular spasm, varicose ulcers, ital ulcers, chilblains, Meniere's syn- e and vertigo.

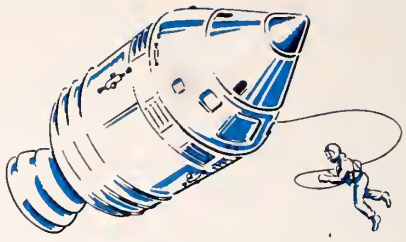
Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE **Roche** LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Man in space, naw fait accampli, re-emphasizes the impartance of Ura-Phasphate therapy. Research inta the effect of space travel on the astranaut reveals that weightlessness causes lass af bane calcium. As the banes are required ta bear less and less of the weight af the bady they lose calcium, increasing the calcium cantent af the urine. When physical activity is reduced, the acidity of the urine shauld be adjusted ta keep increased calcium in salutian a praphylaxis ta prevent kidney ar bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet cantains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

Far pratectian of the inactive patient 1 ar 2 tablets every 4 to 6 haurs is usually sufficient ta keep the urine clear, acid and sterile.

2 tablets an retiring will keep residual urine acid and sterile, cantributing to camfart and rest.

A clinical supply will be sent ta physicians and haspitals an request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

ORGANIZATION SECTION

November Lecture To Honor Doctor Sidney Johnson

A lectureship honoring Sidney Evans Johnson, M.D., will be held at Lourdes Hall, St. Joseph Infirmary in Louisville on November 7, according to S. R. Scheen, M.D., KMA Secretary.



Dr. Johnson

The guest lecturer will be Richard Chamberlain, M.D., professor of radiology and chairman of the department of radiology at the University of Pennsylvania School of Medicine.

Two lectures will be presented, the first at 9 a.m. entitled "Johnson's Temptation" and the second at 7 p.m. on "Radiology Beyound the Eastern Horizons." Both lectures are of general medical interest.

Doctor Chamberlain has recently adopted the University of Saigon Medical School Department of Radiology for the purpose of training Vietnamese radiologists.

Doctor Johnson has had an influence on the careers of many Kentucky physicians in his role as professor of gross anatomy and radiology at the University of Louisville Medical School and as chairman of the x-ray department at St. Joseph Infirmary from 1926 until 1962.

Presently retired, Doctor Johnson lives in St. Petersburg, Florida.

Continuing Medical Education Now Presented in TV Series

A series of 13 continuing medical education programs are being presented in weekly broadcasts this fall over the Kentucky Educational Television Network and WKPC-TV (Channel 15 in the Louisville area), according to William P. VonderHaar, M.D., KMA-ETV Committee Chairman.

The programs, which are broadcast every Monday at 9:30 p.m. EST over KETV and 10:00 p.m. EST over WKPC-TV, are sponsored by the Kentucky Medical Association, the Kentucky Chapter of the American Cancer Society (which provided a grant to defray part of the costs), the University of Kentucky Medical Center, and the University of Louisville School of Medicine.

The first program, presented October 6, was entitled "Lymphomas: How Often Fatal." Future programs in the series include "Gastric Cancer," "Football Injuries: Their Management and Prevention," "Psychotomimetics and Their Abuses," and "The Clinical Use of Electrical Pacemakers." Additional information will be mailed to all Kentucky physicians very soon.

Check your local newspaper for the channel number of the KETV station nearest you.

Transplant Surgeon To Deliver L.E. Smith Lecture Nov. 6

James D. Hardy, M.D., chairman of the department of surgery at the University of Mississippi Medical Center, will give the annual L. E. Smith Memorial Lecture on November 6 at 4:30 p.m. in the hospital auditorium of the University of Kentucky Medical Center.

Doctor Hardy, who with his associates performed the world's first human lung transplantation in 1963, was the first surgeon to replace the human heart by transplantation in 1964.

The lecture is sponsored by the Kentucky Tuberculosis and Respiratory Disease Association and the Kentucky Thoracic Society as a memorial to the late Doctor Smith, who for many years led the fight against TB in Kentucky.

Ky. Thoracic Society Conference Features Lung Transplants, TB

The fall conference of the Kentucky Thoracic Society will be held November 7 and 8 at the Boone Tavern Hotel in Berea. Invitation is open to all physicians.

Sessions on lung transplantation will be led by David Blumenstock, M.D., Mary Imogene Bassett Hospital, Cooperstown, N.Y., and Paul Stevens, M.D., director of Pulmonary Laboratory, Methodist Hospital, Houston.

The conference will open with a dinner meeting November 7, featuring State Senator Clyde Middleton who will discuss "TB versus the Commonwealth." Senator Middleton is chairman of the Comprehensive Health Planning Advisory Council.

Other participants in the two-day session are Robert Penman, M.D., director of the Pulmonary

Disease Section, University of Kentucky Medical Center; Vernon N. Houk, M.D., deputy chief of the TB branch, Communicable Disease Center, Atlanta; and George Brockman, M.D., Greenville, chairman of the TB Study Committee of the Kentucky Comprehensive Health Planning Commission.

Scientific sessions will run from 8:30 a.m. until 2:30 p.m. on Saturday. Approval of American Academy of General Practice for elective credit hours is pending.

Further information may be obtained from the Kentucky TB and Respiratory Office, Louisville.

AMA Approves 2-Year Curriculum For Medical Assistants

The House of Delegates of the American Medical Association approved a two year medical assistant curriculum at its July meeting in New York.

The curriculum is based on the American Association of Medical Assistants' certification study outline.

Applications are being accepted by the AMA's Department of Allied Medical Professions and Services, although it will be several months before the AMA-AAMA team begins to evaluate schools.

KMA Adds 28 Physicians To Its Membership

Twenty-eight physicians have joined the Kentucky Medical Association recently, according to the membership department records as of September 15. This addition of members boosted the total membership figure to 2376 member physicians.

New members in Louisville include Burns M. Brady, M.D., Alfred L. Chatham, M.D., Robert C. C. Chiu, M.D., Chester L. Davidson, M.D., James W. Harkess, M.D., Walter Lang, M.D., Carlos A. Leguizamon, M.D., John J. Martin, M.D., Myron G. Sandifer, M.D., and Albert Weinshelbaum, M.D.

The nine new members from Lexington are Abram S. Benenson, M.D., David J. Brecount, M.D., Allen Evans Grimes, Jr., M.D., Arthur A. Hellebusch, M.D., Edward C. Hightower, M.D., William T. Maxson, II, M.D., R. Herman Playforth, M.D., James E. Russell, M.D., and Tatsuo Yoneyama, M.D.

Other new members are Billy R. Allen, M.D., Beaver Dam, Henry R. Bell, M.D., Elkton, Harold R. Gillespie, M.D., Whitesburg, Paul R. Lewis, M.D., Olive Hill, William N. Richardson, M.D., Cadiz, Remigo T. Roque, M.D., Lynch, Pravit Senavinin, M.D., Barbourville, Sam H. Traughber, M.D., Hopkinsville, and C. W. Van Hooser, M.D., Madisonville.



Newborn Symposium Set Nov. 6-7

The third annual Newborn Symposium will be presented by the department of pediatrics of the University of Louisville School of Medicine on November 6-7, according to Billy F. Andrews, M.D., director of newborn services.

The symposium, which will deal with respiratory problems in the newborn, will feature Donald Buckner, M.D., Lawrence Davis, M.D., Peter Gruenwald, M.D., Marshall Klaus, M.D., Nicholas M. Nelson, M.D., and William A. Silverman, M.D. Further information may be obtained from Doctor Andrews who is in charge of the arrangements.

MLA Holds Annual Meeting

The 68th Annual Meeting of the Medical Library Association will be held October 27-30 in Louisville, according to Joan Titley, librarian of the Health Sciences Library at the University of Louisville. A slate of continuing education courses for health sciences librarians will be featured to help keep MLA members up-to-date in their rapidly changing fields.

New Surgery Division at U.K.

A Division of Otolaryngology has been implemented in the University of Kentucky College of Medicine's Department of Surgery. The division, headed by Glenn Edgar Hair, M.D., officially went into operation on July 1, 1969. Doctor Hair was associate professor of surgery (otolaryngology) at the University of North Carolina School of Medicine before coming to the University of Kentucky.

Seminar Planned by KAGP

The Kentucky Academy of General Practice is holding a seminar October 17-19 at Park Mammoth Resort, Park City, according to Ollie Emerine, M.D. and David T. Lewis, M.D., co-chairmen for the seminar.

Program themes include "General Psychiatry" on Saturday and "Sexual and Marital Problems" for the Sunday sessions. Seven accredited hours will be accepted by the American Academy of General Practice for this seminar.

U.K. Names New Chairman

Abram S. Benenson, M.D., has been named professor and chairman of the Department of Community Medicine at the University of Kentucky. Doctor Benenson is a former professor of preventive medicine at Jefferson Medical College in Philadelphia.

Doctor Benenson succeeds Kurt W. Deuschle, M.D., who organized at the University the first department of community medicine among medical schools in the United States.

Maternal Mortality

(Continued from Page 724)

the disease. The treatment of carcinoma of the breast during pregnancy is still controversial. It has not been established that pregnancy is an important influence on breast carcinoma. Some series indicate that breast carcinoma grows rapidly during pregnancy while others indicate that the reason for the poor survival rate is that the delay in diagnosis on the part of the patient and the physician during pregnancy is so much greater than in the non-pregnant state.

Deaths In The Hospital

(Continued from Page 751)

References

1. Cited from The Record: Deaths on first or second hospital day. *Commission on Professional and Hospital Activities.* Vol. 3: August, 1965.
2. Cited from The Record: Death and autopsy rates for 50 leading causes of admissions, 1963. *Commission on Professional and Hospital Activities.* Vol. 3: February, 1966.
3. Kentucky Vital Statistics: Department of Health. 56th Annual Report: P. 3, February, 1969.

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

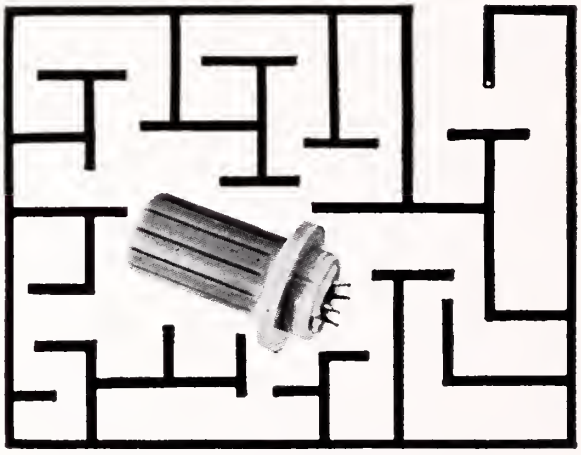
NEWS ITEMS

Thomas P. Leonard, Jr., M.D., a general practitioner, has opened an office in Shelbyville. A 1965 graduate of the University of Louisville School of Medicine, Doctor Leonard completed his internship at St. Joseph Infirmary and his residency training at Louisville General Hospital.

V.R. Fuson, M.D., a general practitioner, has opened an office in Clarkson. Doctor Fuson graduated from the University of Louisville School of Medicine in 1967 and completed his internship in Jacksonville, Fla. in 1968.

Carlos A. Leguizamon, M.D., an internist, is associated with Irving B. Perlstein, in Louisville. A 1946 graduate of Cordoba Medical School, Argentina, Doctor Leguizamon has practiced in Argentina, the state TB Hospital, Glasgow, and Hazelwood Hospital, Louisville.

James E. Russell, M.D., an orthopedist, is practicing in association with O.B. Murphy, M.D., T.D., Yocum, M.D., G.M. Gumbert, M.D., and W.G. Wheeler, M.D., in Lexington. A 1962 graduate of Vanderbilt University School of Medicine, Doctor Russell served his internship and orthopedic surgery residency at Vanderbilt Hospital. He served in the U.S. Air Force Medical Corps, Ft. Worth, from 1964 to 1966.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

Curtis W. Van Hooser, M.D., a specialist in internal medicine, is practicing in association with the Trover Clinic in Madisonville. A 1962 graduate of the University of Tennessee Medical School, Doctor Van Hooser completed his internship at St. Joseph Hospital in Memphis and his residency at Veterans Hospital in Memphis in March, 1969.

Robert C. C. Chiu, M.D., specializing in orthopedic surgery, is associated with James Harkess, M.D. in Louisville. Graduating from the University of the Philippines Medical School in 1956, Doctor Chiu took his residency at Montreal General Hospital in Montreal which he completed in 1963. Having practiced previously at the Burns Clinic in Michigan, Doctor Chiu is on the faculty at the University of Louisville School of Medicine.

Allen E. Grimes, Jr., M.D., a specialist in general and vascular surgery, is practicing in association with Harold Faulconer, M.D., Lexington. A 1962 graduate of Northwestern University Medical School, Doctor Faulconer completed his residency at the Mayo Clinic in 1967.

Sam Traughber, M.D., an internal medicine specialist, is associated with James Dade, M.D., in Hopkinsville. A 1965 graduate of the University of Louisville School of Medicine, Doctor Traughber completed his internship in 1966 and his residency in 1969 at Vanderbilt University Hospital.

Tatsuo Yoneyama, M.D., a pathologist, is an assistant professor in the department of pathology at the University of Kentucky College of Medicine. Graduating in 1954 from the Hokkaido University School of Medicine, Doctor Yoneyama completed his internship in Tokyo and his residency at Duke University in 1962.

Abe R. Fosson, Jr., M.D., a pediatrician, is practicing in association with the Lexington clinic. A 1964 graduate of Vanderbilt University, Doctor Fosson completed his residency at Los Angeles Childrens Hospital in 1966. He served as a captain in the United States Air Force from 1967 to 1969.

Stanley R. Huffman, M.D., a physician in internal medicine and gastroenterology, is now associated with the Houston-McDevitt Clinic in Murray. Doctor Huffman graduated from George Washington University in 1963 and completed his residency at the University of Kentucky Medical Center in 1969.

Harry E. Altman, M.D., a specialist in obstetrics and gynecology, is practicing in association with David K. Mulliken, M.D., Pikeville. A 1965 graduate of the University of Tennessee, Doctor Altman completed his residency in 1969 at the University of Tennessee. He is a member of the Tennessee Army National Guard.

Richard L. Bolton, M.D., specializing in orthopedic surgery, is now at the Trover Clinic. Graduating from Louisiana State University in 1961, Doctor Bolton completed his internship at Confederate Memorial



Ornade® Spansule®

brand of
sustained release capsules

Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

SK&F **Smith Kline & French Laboratories**

Hospital and his residency in 1969 at Tulane University.

William T. Maxson, II, M.D., a specialist in internal medicine, is in association with Irving Kanner, M.D., and Lee Shine, M.D., in Lexington. A 1964 graduate of the University of Kentucky, Doctor Maxson completed his internship and residency at Johns Hopkins University. He has been in the medical corps of the Army National Guard for five years.

Charles H. Griffith, M.D., a pediatrician, is practicing at the Lexington Clinic. Doctor Griffith graduated from Vanderbilt in 1964, completed his internship there in 1965 and did his residency there and at the University of Kentucky.

R. Herman Playforth, M.D., a specialist in general and cardiovascular surgery, is practicing in association with James B. Holloway, Jr., M.D., in Lexington. A 1963 graduate of Johns Hopkins University, Doctor Playforth completed his internship and residency at the University of Kentucky.

Richard F. Plant, M.D., a gynecologist, is now at the Trover Clinic. A 1960 graduate of the University of Arkansas, Doctor Plant completed his residency at Grady Hospital, Atlanta, in 1967. Before coming to Kentucky, Doctor Plant was practicing at the Quincy Clinic, Quincy, Illinois.

Allan W. Lohaus, M.D., a general practitioner, is practicing in association with the Neighborhood Health Center in Louisville. Receiving his M.D. in 1968 from George Washington University, Doctor Lohaus completed his internship in 1969 at Mountainside Hospital in New Jersey.

John J. Johnson, M.D., specializing in opthalmology, is practicing in association with George H. Widener, M.D., in Paducah. A 1962 graduate of the University of Arkansas, Doctor Johnson completed residency at St. Luke's Hospital in St. Louis and at the University of North Carolina in 1969.

Daniel A. Tobin, M.D., a specialist in therapeutic radiology, is associated with the Radiation Center in Louisville. Before coming to Kentucky, Doctor Tobin was a faculty member at the University of Wisconsin and was a general surgeon practicing in Sacramento, California.

Usual and Customary

(Continued from Page 721)

made to the policyholder. The physician is still free to bill the patient in any amount he deems appropriate.

It is apparent that if many physicians do not choose to participate, the Usual and Customary Fee Program will not be effective. Since the consumer has purchased this type of coverage, and has demanded it, it becomes apparent that he will determine which physicians participate in this program and which do not, and will patronize those physicians who do participate. This is free choice of physicians, which we have long supported.

If partnership is to continue between the Blue Shield plan and the Kentucky physicians, it is important that the physicians continue to be active in the policy-making and operation of Blue Shield. We certainly hope that this continues as in the past, and we would encourage individual physicians to sign their indication of participating in Blue Shield, realizing that they may withdraw from the program at any time.

LEWIS DICKINSON, M.D.

Presidential Address

(Continued from Page 767)

the student—this opportunity to establish rapport—can bear significantly beneficial results to both groups.

This year, for the first time, representatives of the SAMA organizations at both medical schools were invited to present a report to the House of Delegates of KMA. They were well received. This year, too, representatives of SAMA were appointed to non-voting membership on our Plans and Development Committee. If the experiment in Jefferson County is successful and, hopefully, is followed by similar efforts in Fayette County, it might be expected that, in the not too distant future, students will also participate more actively in our activities on the state level.

In these rambling remarks I have touched upon a great many subjects. In some I have attempted to report to you the actions and decisions of your Association during the past year, while in others I have expressed my personal opinions on the problems and issues confronting us. Like others who have preceded me in this office, I would like to feel that all of my plans had been completed, all of my goals had been accomplished. That this is impossible is obvious — not only because of my own limitations but because ours is a dynamic profession — always changing, always growing — and the challenges will forever be before us. What has been accomplished is due, in large measure, to the cooperation and understanding of the other officers, the Board, the committeemen, and a wonderful staff. To them my heartfelt thanks for a job well-done. To you, again, my gratitude for the privilege of serving as your President. Thank you.

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

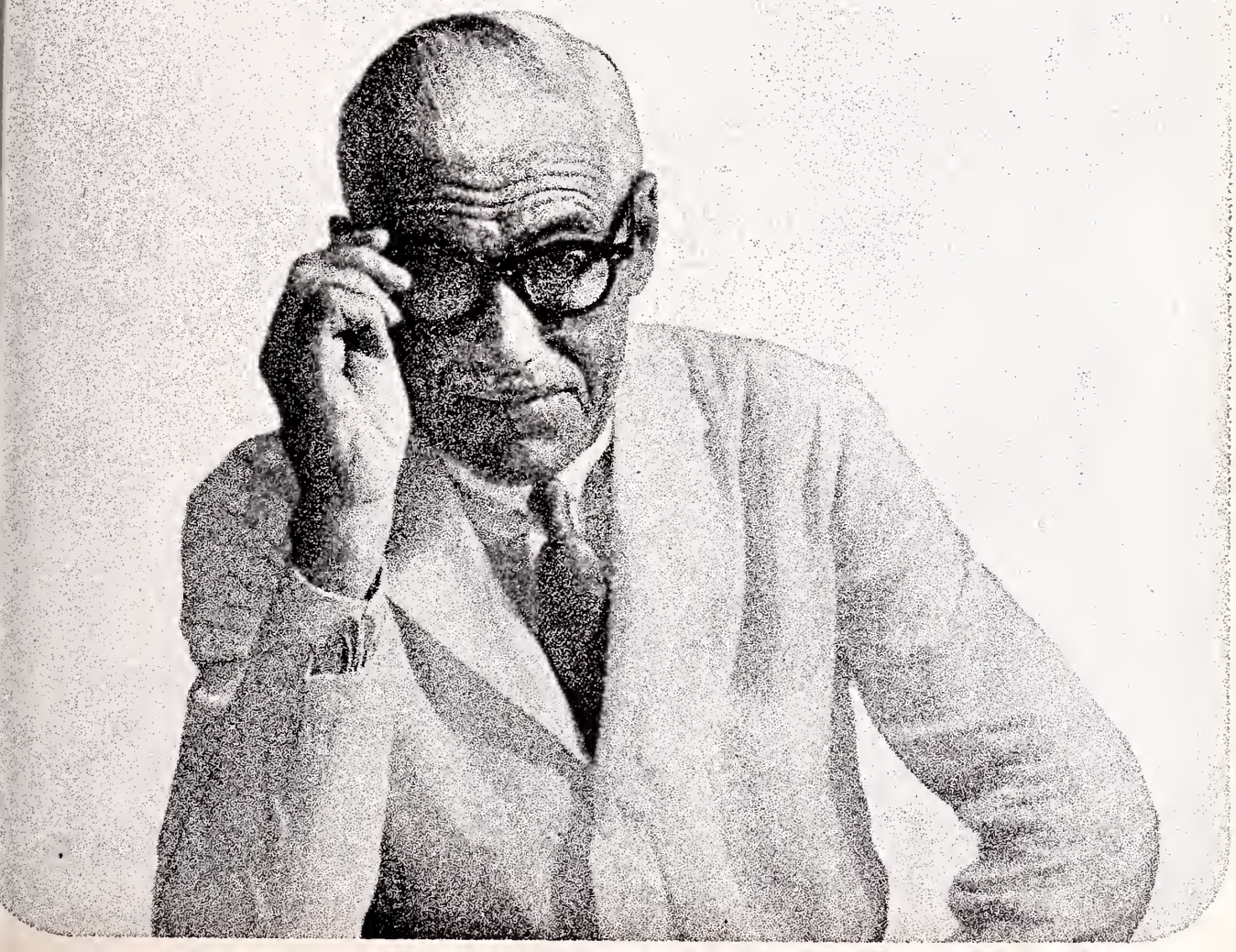
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1969-70

Officers

WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665 President
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 President-Elect
HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 Immediate Past President
DAVID A. HULL, 2101 Nicholasville Rd., Lexington (606) 277-5711 Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661 Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211 Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282 Vice-Speaker—House of Delegates
WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 Chairman of the Board of Trustees
THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 .. Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

1st District C. C. LOWRY, 104 N. Fifth St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362 .. 1971
5th District JOHN S. LLEWELLYN, 510 Heyburn Bldg., Louisville (502) 584-2173 1972
6th District PAUL J. PARKS, 1109 State St., Bowling Green (502) 842-0111 1972
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525 .. 1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1972
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231 1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406 1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751 1972
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155 ... 1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616 .. 1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357 1972

Buyers Guide

OCTOBER BUYERS GUIDE FOR JOURNAL OF KMA 1969

Americon Concer Society 785
Arch Loborotories 781
Blue Crass-Blue Shield 741
Bristol Loboratories 760
Burroughs Wellcome 775
Compbell Soup 757
Geigy Pharmoceuticols 722-723, 734-735
General Leasing 713
Glenbrook Labarataries 711
Highland Haspitol 771
Hynson, Westcott & Dunning 707
Kentucky Thorocic Society 768
Lederle Labarotories 709, 714, 733, 782
Lilly, Eli & Company 742
Medicol Protective Company 780
Merck Shorpe & Dohme 718-720
Merrell, Wm. S., Company 787
Notianol Drug Company 706, 715-716
Parke, Dovis Company 740
Pfizer Loborotories 728-729
Poythress, Wm. P., Campany 778
Riker Loborotories 712-713
Robins, A. H. Company 736
Roche Labarataries 738-739, 776-777, 788
Sondoz Phormoceuticols 737
Seorle, G. D. & Company 758-759
Smith Kline & French 783
Southern Optical Company 771
Strosenburgh Labarotories 725
Stuart Company 761
Worner-Chilcott 769-770
Wyeth Loboratories 726-727, 762-763, 774

Can one prescription do the work of two?

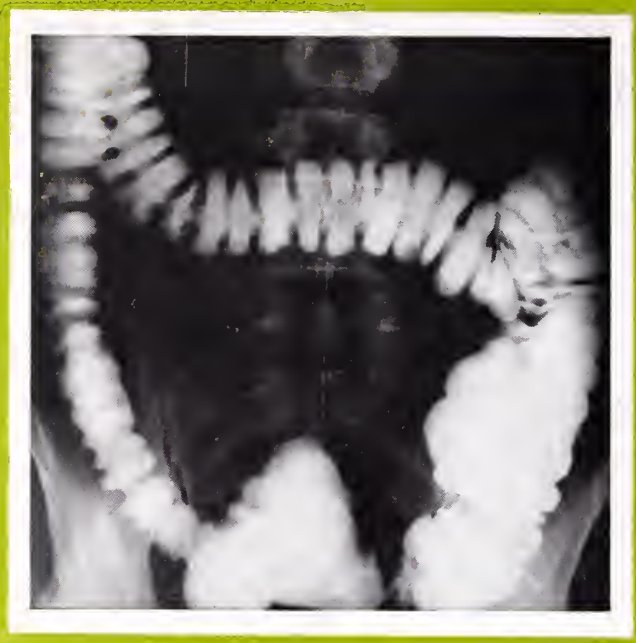


Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

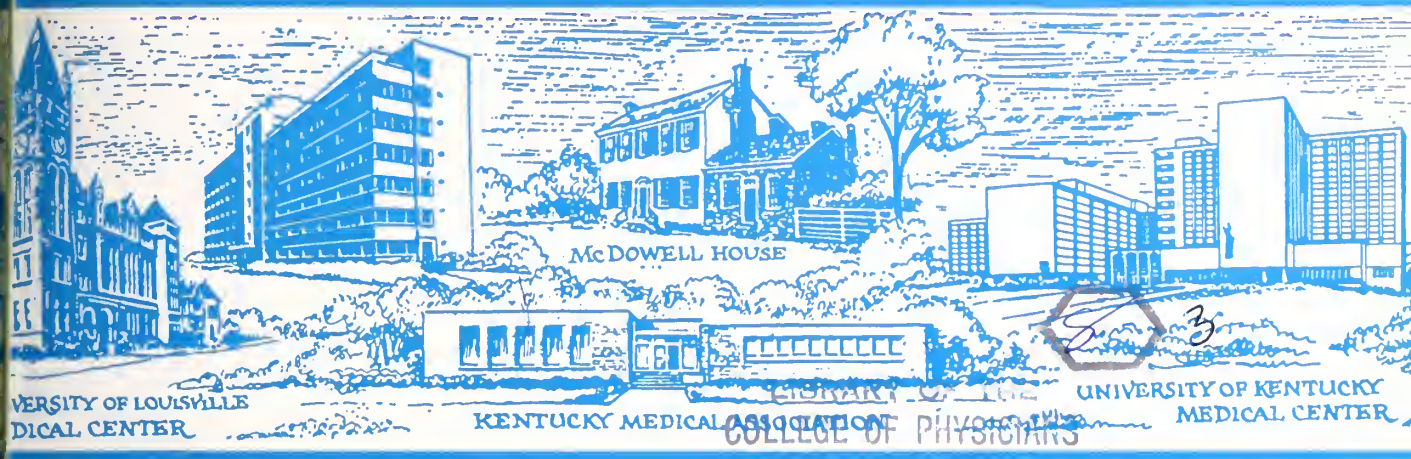
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE **Roche**
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

VOLUME 67 NOVEMBER 1969 NUMBER 11

The Journal of The KENTUCKY Medical Association



LIBRARY OF THE
COLLEGE OF PHYSICIANS

In This Issue

Tetanus Immunity Survey of Six-Year-Old Children
Ibrahim Ildirim, M.D., Affonso R. Meira, M.D. and Michael Furcolow, M.D. 817

Botulism—A Case Report
Harold D. Haller, M.D., R. T. May, M.D. and Richard L. Roth, M.D. 820

An Unusual Complication in Permanent Cardiac Pacemakers
Gary B. Garison, M.D. and R. L. Rainey, M.D. 823

Hemangioma of Spinal Canal
Laszlo Makk, M.D. and Gordon L. Smiley, M.D. 825

Special Article

House Takes Action on Usual and Customary 831

Complete Contents on Page 792



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Cancurrently with MAO inhibitars, in patients hypersensitive ta this drug; in ematianally unstable patients susceptible ta drug abuse.

Warning: Althaugh generally safer than the amphetamines, use with great cautian in patients with severe hypertensian or severe cardiavascular disease. Da nat use during first trimester of pregnancy unless patential benefits autweigh patential risks.

Adverse Reactions: Rarely severe enaugh ta require discantinuatian af therapy, unpleasant symptams with diethylprapian hydrachlaride have been reparted ta accur in relatively law incidence.

As is characteristic af sympathamimetic agents, it may accasianally cause CNS effects such as insamnia, nervausness, dizziness, anxiety, and jitteriness. In cantrast, CNS depressian has been reparted. In a few epileptics an increase in canvulsive episades has been reparted.

Sympathamimetic cardiavascular effects reparted include anes such as tachycardia, precardial pain, arrhythmia, palpitatian, and increased blaad pressure. One published repart described T-wave changes in the ECG af a healthy yaung male after ingestian af diethylprapian hydrochlaride; this was an isalated experience, which has nat been reparted by athers.

Allergic phenamena reparted include such canditians as rash, urticaria, ecchymasis, and erythema. Gastraintestinal effects such as diarrhea, canstipatian, nausea, vamiting, and abdaminal discamfart have been reparted.

Specific reparts an the hematapaietic system include twa each af bane marraw depressian, agranulacytasis, and leukapenia.

A variety af miscellaneaus adverse reactians have been reparted by physicians. These include camplaints such as dry mauth, headache, dyspnea, menstrual upset, hair lass, muscle pain, decreased libida, dysuria, and palyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallawed whale, in midmarning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, ane haur before meals. If desired, an additianal tablet may be given in midevening ta avercame night hunger. Use in children under 12 years af age is nat recammended.

Tepanil® Ten-tab®

(continuous releose form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

T-919A U.S. PATENT NO. 3,001,910 5/59

LACTINEX®

TABLETS & GRANULES

■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

H&WD Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Volume 67 • November 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Diane Maxey

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, M.D., Case Discussions
Lewis Dickinson, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1972
Richard R. Crutcher, M.D.
Chrismon S. Jackson, M.D.
E. Truman Mays, M.D.
Joseph Parker, Jr., M.D.
Elmer G. Prewitt, M.D.
Carl E. Rutledge, Jr., M.D.
Winston Rutledge, M.D.
A. Franklin White, M.D.

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Raddick, Jr., M.D.
Edward C. Shroder, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D
Roy A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
John H. Willard, M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Tetanus Immunity Survey of Six-Year-Old Children
Ibrahim Ildirim, M.D., Affonso R. Meira, M.D. and Michael L. Furcolow, M.D. 817

Botulism—A Case Report
Harold D. Haller, M.D., R. T. May, M.D. and Richard L. Roth, M.D. 820

An Unusual Complication in Permanent Cardiac Pacemakers
Gary B. Garison, M.D. and R. L. Rainey, M.D. ..823

Hemangioma of Spinal Canal
Laszlo Makk, M.D. and Gordon L. Smiley, M.D. .825

SPECIAL ARTICLE

House Takes Action on Usual and Customary
Walter S. Coe, M.D. 831
Medical Credit Cards 832

SPECIAL FEATURE

In Memoriam 840

EDITORIALS

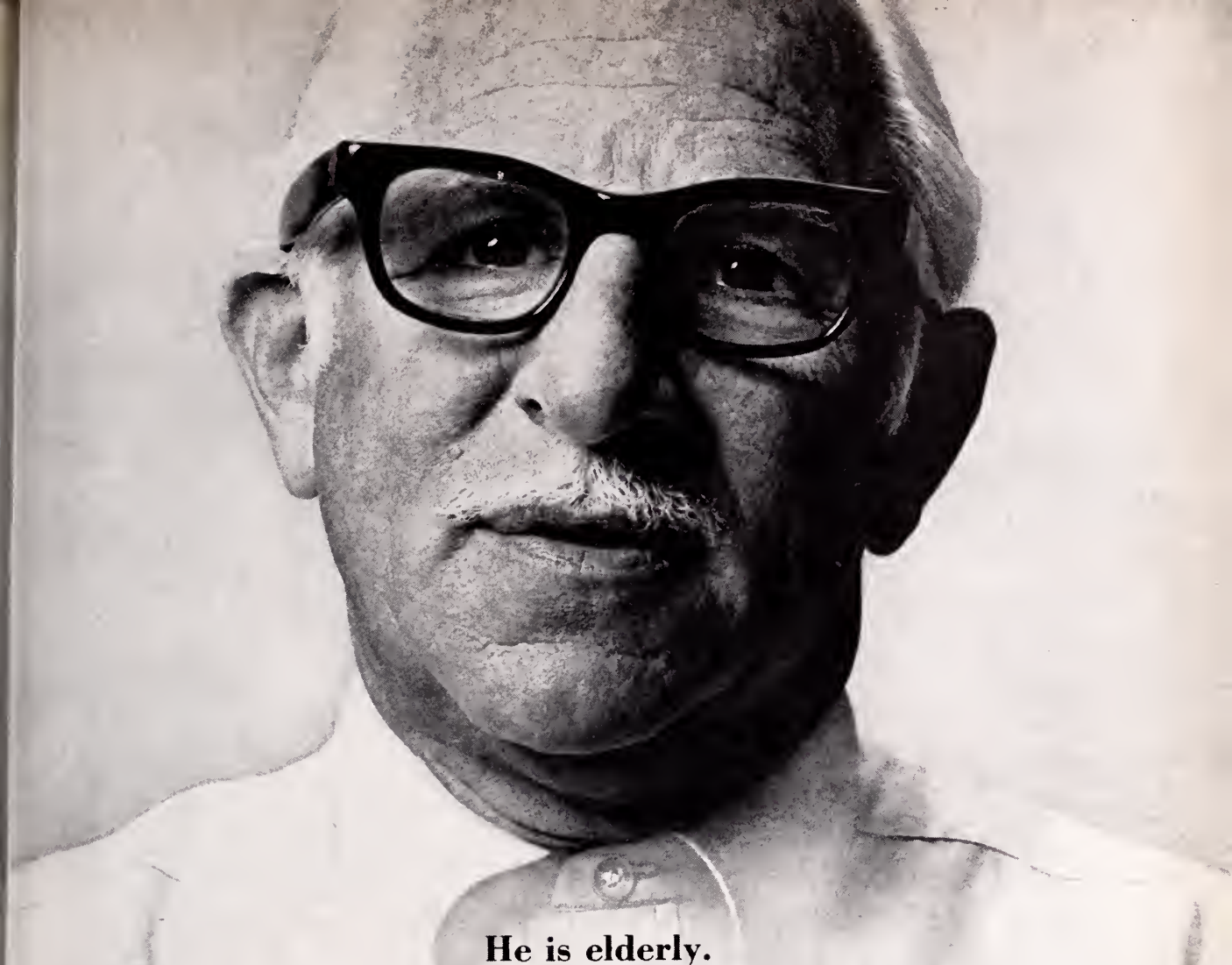
Proposed Changes for the Board of Health
Sam A. Overstreet, M.D. 841

ORGANIZATION

House Elects Dr. Quertermous, Dr. Hull At Annual Meeting 845
Dr. Hall Named Board Chairman, Vice Chairman is Dr. Bryan 845
KEMPAC Physicians Hear Views of Two U.S. Senators At Seminar ..846
Auxiliary Installs Mrs. Gardner, Elects Mrs. Harnaday 847
Farmer KMA President Named As Blue Plans Director 847
Luncheon Speaker Remarks On Current Political Thought 847
Faculty Awards Presented to Drs. Basamwarth, Fishel 852
Two Physicians, One Layman Receive KMA's Top Awards 852
Florida Medical Deanship Goes to Ex-U.L. Dean, Dr. Smith 852
KMA Again Attains Record Membership For 1969 853
KMA House of Delegates Summary 854

REGULAR FEATURES

President's Page 794
Maternal Mortality 798
Public Health Page 801
In The Books 805
Insurance Page 815
Postgraduate Opportunities ..834



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

MESSAGE FROM THE PRESIDENT



LAST year over three and one half million trained persons were actively engaged in one way or another in the provision of health care for our nation's people. It has been estimated that an additional **million** are necessary **now** to make up existing deficits in many areas. Furthermore, by 1975 the health care "industry", if I dare call it that, in order to keep pace with the demand, will require that ten per cent of each high school graduating class be directed into a health career.

A gigantic problem in recruitment is upon us. The Commonwealth has been fortunate this past year in having "Health Careers in Kentucky" get off to such an auspicious start. This organization in a short time has helped to crystallize many of our recruitment efforts. Your KMA Health Careers Committee as well as the Auxiliary is cooperating fully with them.

However, they can't do it all. To accomplish what is required will demand that each physician in the Commonwealth become an active recruiter.

In your daily practices, you have the opportunity to identify these people, young or mature, who ought to be guided into a health profession or occupation. Spend a few minutes of your time in discussing with them this possibility. A large proportion of our present students have been pointed toward a health career on the advice and counsel of their physician.

If each year, each of you would selectively recruit just **one** person, we could add 3,000 health workers annually to our dwindling supply.

JOSEPH HAMBURG, M.D.
SCHOOL OF ALLIED HEALTH PROFESSIONS
UNIVERSITY OF KENTUCKY MEDICAL CENTER

This is the first in a series of articles written at the request of KMA President Walter L. Cawood, M.D.

Hoechst is proud to be able to offer
nearly 100 years of patient-centered research
to "bridge" the sometimes awesome chasms of medicine.



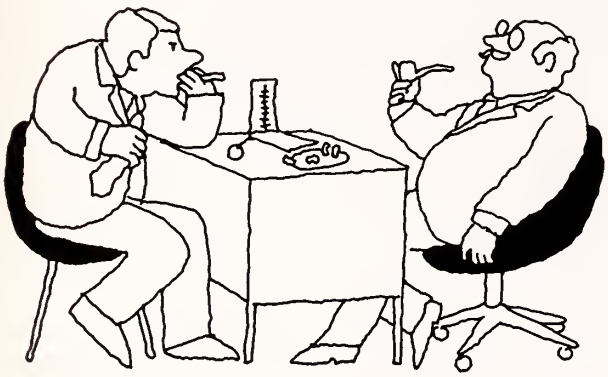
"Life is short and art is long;
the crisis is fleeting,
experiment risky,
decision difficult."

HOECHST PHARMACEUTICAL COMPANY, Cincinnati, Ohio 45229
Division of American Hoechst Corp.

HOECHST

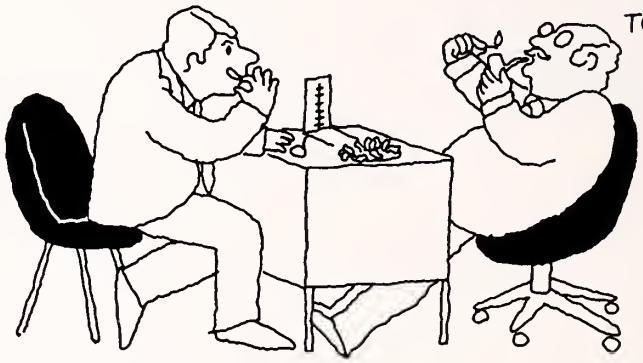
Major discoveries of Hoechst world-wide research include procaine, arsphenamine, mersalyl, tolbutamide, and furosemide.

The Apprehensive Hypertensive



WELL, YOU HAVE WHAT WE CALL MODERATE HYPERTENSION— HIGH BLOOD PRESSURE. NOW I DON'T WANT YOU TO WORRY, BUT WE ARE GOING TO HAVE TO CHANGE A FEW LIVING HABITS. FIRST, WE'RE GOING TO HAVE TO CUT OUT SMOKING—ALTOGETHER.

THEN WE HAVE TO LOSE WEIGHT. 20 POUNDS SHOULD DO IT... WE'LL TALK A LITTLE LATER ABOUT THIS DIET WE'RE GOING TO START.

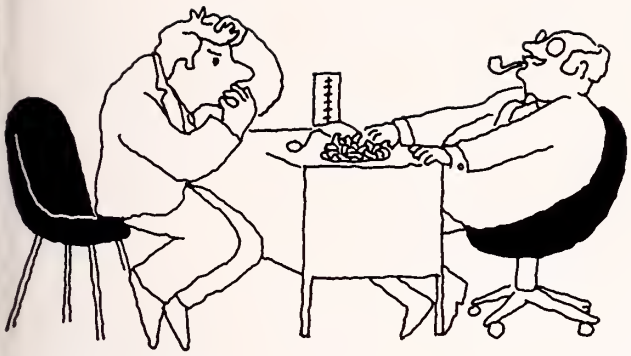


Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



WE'VE GOT PROBLEMS.



and allay anxiety in hypertension

corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE 19-67. This 24 year old married white gravida 2, para 1 was a private patient admitted to the hospital at 6 a.m., November 24, 1967, in active labor. EDC was November 3, 1967. She was moderately obese weighing approximately 170 pounds, 5'8" tall. She had no difficulty with her first pregnancy. Blood pressure on admission was 170/90, temperature 98, pulse 68, Rh positive, hematocrit 39 per cent, Hb 12.4 gr. Vaginal examination revealed the cervix to be 7 cm. dilated. She was having contractions every two - five minutes that were described as hard. Demerol 75 mg, 20 mg Largon and Scopolamine were given at 7:10 a.m. She was taken to the delivery room at 10:20 a.m. and given a general anesthetic (N_2 O and either). A 10 pound 10 ounce male was delivered over a left mediolateral episiotomy with forceps at 11:10 a.m. The placenta was expressed at 11:15 a.m.; following which excessive postpartum bleeding occurred that responded to Pitocin 1 ampule, Methergin 1 ampule and 1000 cc D5W with 2 cc of Pitocin.

The following was obtained from the nurses' notes. The uterus was described as large but firm at 11:40 a.m., blood pressure 140/90. The uterus was massaged frequently and remained firm. At 12:30 p.m. her blood pressure was 100/60 and pulse 120, the fundus was described as firm. She complained of back ache and received Darvon at 1:20 p.m. At 2:40 p.m. her blood pressure was 70/50 and pulse 120, pads were changed. Her physician was notified. He ordered 25 mg Ephedrine IM and external heat applied. Her blood pressure remained low—80/50. At 3:10 p.m. her blood pressure was 80/30 and pulse 120. At 3:20 p.m. blood pressure was 80/30 and pulse 120. The fundus was massaged and the IV fluid was absorbed. At 3:45 p.m. blood pressure was 70/0 and pulse 100. She was turned on her side. The bleeding was described as excessive, and the patient's physician again was notified. The patient was described as very restless at 4 p.m., her blood pressure 70/0. Type and cross match was ordered for 1000 ml blood. The patient was cold, clammy and complained of thirst. At 4:30 p.m. her blood pressure was 70/0 and the pads were changed; patient's physician notified at 4:45 p.m. that the blood pressure was 50/0. At 5:00 p.m. the patient expired by the time the physician arrived.

An autopsy was obtained, the positive findings were 1200 cc of clotted blood in the uterine cavity. In the vaginal vault at the junction of the cervix a first degree laceration was described without evidence of hemorrhage. She had approximately 150 cc clotted blood behind the perineal pad.

A single midline incision was made just beneath the suprasternal notch to the symphysis to facilitate examination for possible air embolism. The lungs were collapsed. The heart was opened, submerged beneath water in its pericardial sac, there was no evidence of air embolism. The abdominal cavity contained no free fluid.

The final diagnosis was death from acute blood loss.

Comment

The committee classified this maternal death as a direct obstetrical death with preventable factors on the part of the physician. It was conjectured that possibly the physician was indeed very busy this afternoon and not available to properly care for this patient. Death was obviously due to blood loss from postpartum hemorrhage. Treatment should have consisted of more vigorous efforts early in the afternoon to control the bleeding by the use of oxytocics and re-examination of the patient to see if there were vaginal or cervical lacerations or possibly a retained placenta causing the continued bleeding which was noted in the nurses' notes. The patient could have been maintained with intravenous fluids and blood when necessary. Of course, the diagnosis of the etiologic factor is paramount in these cases before instituting treatment. It is noted that postpartum hemorrhage occurs in less than five per cent of all deliveries. In practically every instance this bleeding can be controlled and blood can be replaced rapidly. No woman should die as a result of postpartum hemorrhage in the modern hospital today. It has been documented that deaths from postpartum bleeding are rarely caused by sudden overwhelming hemorrhage. In a study by Beecham[1] none of the patients died in less than one and a half hours and only 11.5 per cent died within two hours. The average time between delivery and death was over five hours. With this in mind every physician should realize that he has adequate time in order to take measures to diagnose and treat this condition so that maternal death will not occur.

References

1. Page 462, *Obstetrics & Gynecology*, Willson, J. R., Beecham, C. T., and Carrington, E.R., Third Edition, C. V. Mosby Co., St. Louis, Missouri, 1966.



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

AVC SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK. A V C

AV-919A 7/69

PUBLIC HEALTH PAGE

Kentucky Medical Assistance Program†

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE seeds of the Kentucky Medical Assistance Program were sown as early as 1939 and 1953 when the Kentucky Medical Association expressed concern over the financing of medical care for the indigent in Kentucky. The Association concluded in 1953 that with "relatively few exceptions[1]," medical care for the indigent was provided by health professionals and facilities gratuitously. In 1957 the Governor appointed the Commission on the Study of Medical Care for the Indigent and as a result of its work, the Kentucky General Assembly in 1960 established the Kentucky Medical Assistance Program, under which payment would be made to providers of medical services rendered to indigent persons.

The Act designated the Department of Economic Security as a single state agency, and charged that Department to contract with the Department of Health for all the medical care aspects of the Program. The specific functions of each Department were defined in the law. An Advisory Council for Medical Assistance, comprised of health professionals and consumers, was created and given responsibility for advising both departments on the development and formulation of policies, plans, budgets, programs and rules and regulations relative to the Program. Six Technical Advisory Committees, one for each major professional group, were also established to advise the Council on technical matters and to conduct liaison between the Council and the professions.

The Program has played an important role in the health economy of Kentucky. It serves approximately ten per cent of the state's population. It encouraged the development of high criteria nursing homes, which expanded from six in 1963, when nursing home benefits were instituted to 71 in September, 1969. It fostered the expansion of home health care services from two agencies in Kentucky in 1966, when home health agency benefits were added, to the present 30. The dental program is designed to encourage the preservation of children's teeth, and it has seen a decline since 1961 in the percentage of extractions as compared with restorations. When the Program began in 1961, it provided very minimal hospital, physician, dental and pharmacy benefits. Since then, independent laboratory, home health agency, hospital outpatient, mental and TB hospital, community mental health center, deductibles and coinsurance, have all been added in gradual phases to Program coverage.

The physician's program began with token benefit of $2 and $3 for office and home calls in 1961, and later was liberalized to $3 and $5 respectively. This payment, if the physician wished to request it, represented his full payment for the service he rendered. Physician benefits remained unchanged until implementation of the Title XIX "Medicaid" bill made possible a significant expansion, including the first benefit for physicians' in-hospital services.

Although the Advisory Council for Medical Assistance endorsed the principle of payment for usual, customary and prevailing fees for physicians' services as early as 1967 it was not until the 1968-69 fiscal year that funds were made available to begin payment of such fees, for outpatient services only. The usual and customary fee system gives the physician considerably more flexibility in the procedures for which he can bill and recognizes the characteristics of geography and economics prevalent in each medical service area.

In the first year of the usual, customary and prevailing payment mechanism, physicians' bills were processed for 45 per cent of the persons eligible for services, each of whom received at least one physician's service and on the average, received 5.73 procedures during the year. Over $6 million was paid out in the fiscal year under the usual and customary

†*This article was prepared by: Anne A. Thompson Director, Medical Assistance Program, Kentucky State Health Department, Frankfort, Kentucky*

When trauma results in pain, try Norgesic first... your patients probably won't need anything stronger

Sprains, strains, fractures...Norgesic offers predictable relief in the great majority of traumatic injuries where both pain and muscle spasm are involved. Unlike "pure" analgesics or muscle relaxants, Norgesic affects both components of musculo-skeletal pain, providing effective analgesia and relief of associated muscle spasm.

Norgesic works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer. Thus, when trauma results in pain, try Norgesic first...your patients probably won't need anything stronger.

Indications: Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders. Here, Norgesic demonstrated clinical superiority to APC as an analgesic.

Contraindications: Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy, obstructions at the bladder neck, myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child. USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders.

Adverse Reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, some degree of confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

Available V.A. Supply Depot—FSN6505-952-6762A



NORGESIC®

(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

Riker Laboratories, Northridge, California 91324

Sponsors of Riker Service—the complimentary classified service for physicians.

Public Health Page

(Continued from Page 801)

system to 74 per cent of Kentucky's physicians and averaged $2,892.82 per physician. The average amount paid per person receiving physician's services was $26.81 and the average paid per procedure was $7.47.

In 1967 and again in 1969 the Advisory Council for Medical Assistance recommended usual, customary and prevailing fees for physicians' in-hospital services. This recommendation will be included in the benefit budget request now being compiled for the 1970-72 biennium, but final decisions regarding budget allocations will not be made for some weeks yet.

The Kentucky Medical Assistance Program has advanced considerably since its cautious beginnings in 1961. The growth has not been a runaway situation, but has been planned carefully in consultation with the Technical Advisory Committees and the Advisory Council, with the funds being provided prior to the implementation of any new benefit. This close coordination should prove very beneficial as the Advisory Council and the Kentucky Medical Assistance Program undertakes the development of an advanced utilization review and quality control mechanism to ensure that services provided under the Program are of high quality and in accordance with patient need and modern medical practice. The new utilization review mechanism must also seek to be sensitive to rapidly rising costs of health services and to develop knowledge of patterns of care that might lead toward a solution of the cost problem.

The cooperation in this effort of all physicians in Kentucky will be needed for better services for Kentucky's indigent, and for all citizens. Kentucky physicians have a unique opportunity to pioneer in this work, and the Kentucky Department of Health is eagerly looking forward to working with all physicians for improved health in Kentucky.

References

1. Report of the Committee on Medical Service of the Kentucky State Medical Association, 1953

PSYCHIATRIST, SURGEON, GENERAL PRACTITIONER. 1518 bed predominately psychiatric VA Hospital, located in East Central Indiana. Special programs in psychiatric and geriatric rehabilitation; alcoholic treatment unit. Active medical and surgical services. Family rental units at reasonable rates usually available on hospital grounds. 30 days of leave annually; retirement; health, life insurance plans without physical examination; and other benefits. Can pay moving expenses. Salary depending on qualifications. License any State required. Equal opportunity employer. Contact Chief of Staff, VA Hospital, Marion, Indiana 46952 or call (317) 674-3321, Extension 233.

Dulcolax®...so predictable you can almost set patients by it

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



UNDER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU 668

IN THE BOOKS

CONTROVERSY IN OBSTETRICS AND GYNECOLOGY: by Duncan E. Reid, M.D. and T. C. Barton, M.D. with 60 eminent contributors; Published by The W. B. Saunders Company, Philadelphia, 1969; 404 Pages; Price $15.50.

Controversy in Obstetrics and Gynecology is a long overdue book. The editors use a format which is both intriguing and thoughtful.

In all, 20 separate controversial problems in obstetrics and gynecology are presented. Each subject is treated by two and in some cases three eminently qualified authors. The authors frequently have opposing points of view, which are arbitrated by the editors at the end of each chapter.

As an example, Chapter 3 treats the subject of premature rupture of the membranes. Two diametrically opposed points of view regarding the management of this important obstetrical complication are presented. It becomes evident that the socio-economic status of the patient and the degree of prematurity are the real factors which decide the management to be employed in premature rupture of the membrane . In some instances the editors seem to avoid the issue and do not make positive statements as to desirability of one point of view over another, but rather insinuate their views. The reader is then left to his own conclusions after having read the evidence presented.

At other times the editors state quite definitely their views on the subject. The editorial comments usually extract the salient features of each point of view and try to come to some conclusions.

This book will be very useful in the teaching of medical students and house staff. Nearly all of the most frequently encountered controversial problems in obstetrics and gynecology are thoroughly discussed, and all points of view fairly presented.

The practitioner will gain a great deal from reading this book, particularly those who have been exposed to some of the controversy in the 20 separate subjects covered by this book.

The editors of this important book are to be congratulated on their ingenuity and courage in bringing together appropriate authorities on each side of each controversial subject.

WALTER M. WOLFE, M.D.

SYMPOSIUM ON THE SPINE: by the American Academy of Orthopaedic Surgeons; Published by The C. V. Mosby Company, St. Louis; 1969; 289 Pages; Price $19.50.

This book was developed from an instructional course on the spine which was organized by the Committee on Injuries, American Academy of Orthopaedic Surgeons, and was presented in Cleveland in 1967. The contributors of this monogram are many well-known and respected orthopaedic surgeons from various institutions.

This monogram deals with the various types of fractures and soft tissue injuries of the cervical and lumbar spine, including whiplash injury and low back pain. The mechanics of the injuries and the treatment of these conditions are well covered.

There is one chapter on classification, etiology and treatment of spondylolisthesis, and one chapter on the pathology and treatment of osteoporosis of the spine. There are several chapters on scoliosis, dealing with methods and techniques of evaluating idiopathic scoliosis, pulmonary function on scoliosis and treatment of scoliosis including non-operative ones.

There are 558 excellent illustrations, mostly x-rays. The material in this monogram is well organized and well written and can be read very easily. There are no new ideas or original contributions. It is a rather comprehensive review of recent concepts on management of diseases and injuries of the spine.

I think that it is a worthwhile book for orthopaedic surgeons and especially residents in orthopaedics.

STANLEY W. COLLIS, M.D.

PRACTICAL UROLOGY: by C. C. Winter, M.D.; Published by the C. V. Mosby Company, St. Louis, 1969; 249 Pages; Price $11.00.

Practical Urology by Doctor Winter is a well illustrated textbook of urology designed primarily for the medical student. It provides a general discussion of the various phases of urology. It lacks the detail necessary for one interested in an in-depth study of special problems. There are excellent references at the end of each chapter for those interested in more detailed information. These include classical as well as recent references pertaining to the subject matter. In addition, a list of movies which are available and related to the subject is included at the end of each chapter.

Each chapter relates to one organ and the uropathies related thereto. Thus, it is easy to refer quickly to all disease processes which affect a particular structure. This is of much value to the student in his effort to organize his thinking about organ systems and disease.

This is a good reference volume for the student and general practitioner. Its greatest value is the concise presentation of material and the excellent references which are provided by the author.

LONNIE W. HOWERTON, JR., M.D.

THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to se esteem, *both* anxiety and depression almost always follow.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

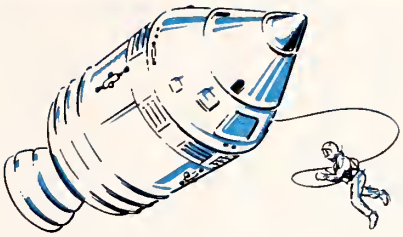
SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co., Inc., West Point, Pa. 19486
where today's theory is tomorrow's therapy



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



Appearances may be deceiving



It may be tetracycline

but it's not ACHROMYCIN® V
Tetracycline HCl

unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

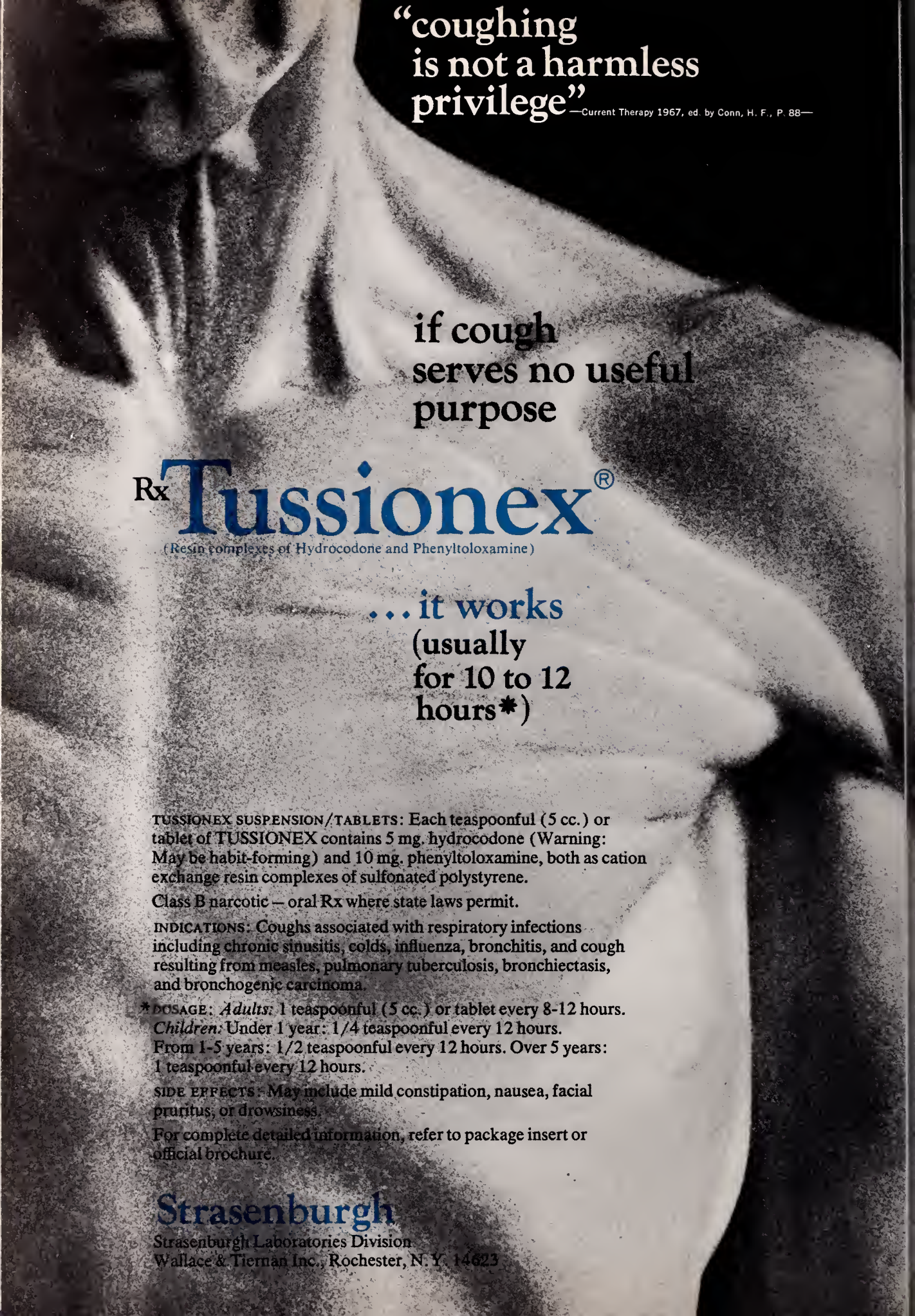
Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

530-9


"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
Rx Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic – oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass
cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.



THE INSURANCE PAGE



Authorization to Furnish Information to Third Parties

THE Insurance Page of your Journal hopes to create interest as well as to disseminate information in the field of insurance. We may not always have information, so at times we must ask questions. At times we may even precipitate controversy. It is through discussion and learning on the part of all members of the State Medical Association that problems are solved.

The lively discussion on the Fayette County resolution about Usual and Customary Fees, as it applied to the new Blue Shield Insurance Policy, is an example of this. Although strong feeling was expressed by both sides of the argument, it created interest and caused most of us to study the problem more thoroughly and thereby benefit by increasing our understanding.

The entrance of a third party into any agreement increases the complications geometrically. It is one phase of the complexity of dealing with third parties that I wish to discuss today.

Each day several letters from insurance companies inquiring about past illnesses and insurability of patients arrive on my desk. They are accompanied by the usual brief form, which is signed by the patient, authorizing his attending physician to give any information concerning his past treatment. It seems to me that most of these inquiries are deliberately inadequate. The insurance underwriter asks a few pointed questions, or asks about one specific disease. In one case that I recall, the underwriter made a specific inquiry about recent treatment for arthritis and further limited the field of question by giving a month and year in which the attending physician allegedly had treated this patient for arthritis.

The office record indeed showed an entry during the month in question. The patient was a tobacco farmer and had sore shoulder muscles due to the vigorous exercise of housing tobacco. He had no arthritis and had not been told that he had arthritis. On rereading the question sent by the insurance underwriter, it again appeared to limit the questions asked to this particular visit, or to this particular month and year. The remaining office records showed that this man had been treated in the past for a duodenal ulcer which had been demonstrated on x-rays, some three years prior to the date in question. The dilemma is whether or not the physician should report this type of information, when no questions were directed toward this.

It has been the writer's policy to report all past history available on the record and to substantiate this report by any laboratory work available. In this way, we feel that we have done this patient a service if the insurance company does not give him an insurance policy. It is the limited inquiry of this type that allows insurance companies to write insurance policies and receive premium payments for one and one-half years and then cancel the contract on the grounds that the patient concealed from the company that he had a duodenal ulcer.

It is the writer's opinion that numerous insurance agents deliberately do this type of underwriting, when the patient assures me that he had given the agent full information about his previous illness.

It is the writer's opinion that the physician should give all available information to any insurance company who presents an authorization signed by the patient. It has been my experience that if considerable time and effort goes into preparing such a report, and it includes documenting x-rays or laboratory reports the insurance company will pay a reasonable fee for this service if the bill is sub-

(Continued on Page 866)


When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
900541

The JOURNAL of the
Kentucky Medical Association

Issued Monthly Under The Direction Of The Board Of Trustees

VOLUME 67 NOVEMBER 1969 No. 11

Tetanus Immunity Survey of Six-Year-Old Children in Lee and Wolfe Counties of Kentucky

Ibrahim Ildirim, M.D..* Affonso R. Meira, M.D..* and
Michael L. Furcolow, M.D.**

Lexington, Kentucky

Using indirect hemagglutination test, the authors measured the tetanus antitoxin level of the serum of 100 children. These children, from Eastern Kentucky, had supposedly been immunized. Seventeen per cent were below the protective level.

In 1965 and 1966, 535 cases of tetanus resulting in 363 deaths were reported to the National Communicable Disease Center in the United States[1]. Tetanus morbidity and mortality rates in the United States have followed a gradual downward pattern since 1950[1], but this is not very impressive as compared with the precipitous drop of diphtheria, whooping cough, and poliomyelitis[2]. In mortality, tetanus now exceeds measles[2]. We believe that 535 cases of tetanus is a minimal figure and that the true incidence of tetanus in the United States is greater. In a recent study, we showed that only 23.5 per cent of tetanus cases in the hospitals of Lexington were reported to the Health Department[3].

Immunization for smallpox, diphtheria, poliomyelitis, pertussis, measles, etc. confers protection not only for the recipient but also indirectly for others because it eliminates persons from the chain of disease transmission. Indirect protection for other persons is not effective in tetanus disease. Tetanus bacilli are found in the intestinal tract of many animals whose manure then contaminates soil. The organism's ability to form spores enables it to survive indefinitely in the soil. The spores, blown along with dust particles, are found in a great variety of places; so all the population should have immunity for the prevention of tetanus. In Kentucky, a law requires all children to be immunized against tetanus before entering school.

Survey of the immunization level by questionnaire does not seem reliable. Tetanus immunization could be forgotten or confused with other immunizations or injections. The most direct way to determine the susceptibility of individuals against tetanus would be by measuring the tetanus antitoxin levels of the person's serum. Indirect hemagglutination tests seem more convenient than standard mice tests for community survey studies because of the lesser expense and time involved. In our

* *Post-doctoral fellows, Department of Community Medicine, University of Kentucky Medical Center, Lexington*

** *Professor and acting chairman, Department of Community Medicine, University of Kentucky Medical Center, Lexington*

study the indirect hemagglutination tests were employed to determine serum antitoxin levels.

Description of the Community

Lee and Wolfe are the most rural counties of Kentucky, according to the 1960 U. S. Census. These two neighboring counties are located in the eastern part of the state in the Appalachian Mountain range. Total population of these two counties was 13,954 in the 1960 Census (Lee, 7,420; Wolfe, 6,534)[4]. The population is quite stable, more than 95 per cent of the population being born in Kentucky. The percentage of non-white is less than 1 per cent. The percentage of persons 25 years old and over who have completed four years of school or less is 27.2 per cent for Lee and 24.6 per cent for Wolfe counties, as compared with the U.S. average of 8.3 per cent.

The annual income per capita is $744 for Lee and $523 for Wolfe, compared with $2,223 for the U.S. average. There are 1,937 and 2,924 persons per physician for Lee and Wolfe counties, respectively[4].

Materials and Methods

Serum samples of six-year-old children were collected and stored at 20° C. This study was in association with the U.S.P.H.S. and the Kentucky State Health Department's Thirteen County Multiphasic Screening Program "Project CH13-6", conducted in 1964. A total population of 275 six-year-old children was estimated in these two counties then (estimate extrapolated from the 1960 Census)[4]. Of the 275 children, 242 were screened, and 100 serum samples were tested for tetanus antitoxin levels. From the total of 100 children, 61 were male and 39, female. There were no non-white children.

Tetanus Antitoxin Titrations

The method used was the indirect hemagglutination technique described by Stavitsky[5], Schubert and Cornell[6], and Levin *et al*[7]. Instead of sheep red blood cells, horse red blood cells were used. The horse blood was obtained fresh in citrate solution (23 ml blood and 27 ml 3.8 per cent sodium citrate). Tetanus toxoid* and standard tetanus antitoxin** were available through the courtesy of Lederle Laboratories and the NIH.

Horse erythrocytes were suspended in pH 7.2 buffer saline solution and washed by centrifuge three times at 2,000 rpm for five minutes. After packing the cells for ten minutes at the same speed, 2.5 per cent suspension of cells was made. This suspension was treated with the same volume of 1:20,000 tannic acid dilution in saline for ten minutes at room temperature and then centrifuged to remove the supernatant. The cells were resuspended in physiological saline to obtain 2.5 per cent suspension.

Sensitization of the horse cells was accomplished with a dilution of toxoid (1 vol. 2.5 per cent tanned cells, 1 vol. 1:16 toxoid dilution, 4 vol. saline buffered pH 6.4). For use as controls, half of the cells were not sensitized (1 vol. 2.5 per cent tanned cells, 5 vol. saline buffered pH 6.4). The exposure of the cells was at room temperature for 15 minutes. The cells were then washed in three times their volume with one per cent rabbit serum diluent in pH 7.2 buffer saline (rabbit serum inactivated at 56° C for 30 minutes with merthiolate solution added as preservative). Final dilution of sensitized and non-sensitized red cells was made 1.25 per cent in rabbit serum diluent.

Every group test procedure was run parallel with standard tetanus antitoxin as the control. All sera were inactivated at 56° C for 30 minutes. Two-fold serial dilutions of serum samples were made in duplicate in test tubes, leaving 0.5 ml in each tube. Then, 0.1 ml of sensitized cells was added to the first row of test tubes and 0.1 ml of non-sensitized cells to the second row (controls) of tubes. The racks were shaken and allowed to stand two hours at room temperature. A positive hemagglutination reaction was indicated by a smooth or rough-edged mat of cells which coated the bottom of the tube, and a negative reaction was recorded when the cells formed a ring on the bottom of the tube[6]. The last positive tube was designated the end point and considered to have the same unitage per milliliter as the end point of the known standard antitoxin which was run with each series. The unitage of

* *Tetanus toxoid lot #61T-86, 625 Lf/ml. Pres. 0.01 per cent thimerosol. Lederle Laboratories division, American Cyanamid Company, Pearl River, N. Y.*

** *U. S. Standard tetanus antitoxin lot #108, 5 unit/ml. Division of Biologics Standards, NIH, Bethesda, Maryland.*

TABLE 1

Distribution of Serum Antitoxin Levels of Six-Year-Old Children by Sex From Lee and Wolfe Counties of Kentucky

County	Serum Tetanus Antitoxin Levels (I.U.)																		Total Both Sexes	Percent Unprotected
	0.002		0.002-0.005		0.005-0.01		0.01-0.02		0.02-0.05		0.05-0.1		0.1-0.2		>0.2		TOTAL			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
LEE	7	2	0	1	0	0	2	3	5	4	3	2	5	2	19	13	41	27	68	14.7
WOLFE	1	4	0	0	2	0	0	0	0	0	1	0	1	0	15	8	20	12	32	21.8
TOTAL	8	6	0	1	2	0	2	3	5	4	4	2	6	2	34	21	61	39	100	17

the unknowns was calculated by applying the dilution factor. All the control rows with unsensitized tanned cells must be negative.

The results were obtained originally in hemagglutination units (HU) rather than in the more familiar international units. Results have been transformed to IU per milliliter, using the formula log IU = 1.0885 log HU-0.6741[8].

Results and Comments

The level of 0.01 AU/ml had been generally accepted as a protective level by authors at the International Conference on Tetanus in 1966[9], so this analysis was made on the basis of this criterion.

Lee County: A total of 68 children were tested, 41 males and 27 females. Seven males and three females, 14.7 per cent of the children, were below the protective level.

Wolfe County: A total of 32 children were tested, 20 males and 12 females. Three males and four females, 21.8 percent of the children were below the protective level.

These two adjacent counties were similar in urbanization, education, economy and health facilities. The results of immune status of six-year-old children against tetanus were also found to be similar although no statistical differences exist between the counties for tetanus immunity.

As viewed in Table I, 17 of these 100 six-year-olds had less than 0.01 units of tetanus antitoxin per milliliter of serum, ten males and seven females. The total test group included 61 males and 39 females. No statistical difference is found between sex groups. All the children had supposedly been immunized; however, we discovered 17 per cent lack of immunization against tetanus. Consequently, their diphtheria and pertussis immunization status may be considered the same since this is generally administered as triple vaccination.

The most recent case of tetanus, in a six-year-old Eastern Kentucky boy admitted to the University of Kentucky Medical Center in February, 1969, was treated at a cost of $8,119.25. With that amount of money spent in preventative measures, a large number of persons could be protected.

Summary

Serum titrations for tetanus antitoxin levels were conducted on serum samples from 100 six-year-old children. The indirect hemagglutination method was employed. One-sixth, or 17 per cent of these children were found below the protective levels. No significant difference was found between the sexes or the counties.

References

1. LaForce, F. M., Young, L. S., and Bennett, J. V.: Tetanus in the United States (1965-1966): Epidemiologic and Clinical Features. *New Eng. J. Med.*, 280:569 574, March, 1969.

2. Ipsen, J.: Tetanus-Still Here? *New Eng. J. Med., 280:* 614, March, 1969.

3. Meira, A. R., Ildirim, I., and Furcolow, M. L.: Tetanus in the Bluegrass Area: A Report of Recorded Cases in the Hospitals of Lexington, Kentucky, from 1960-1968. *J. Ky. Med. Assoc.*, July, 1969.

4. Brown, J. S., and Ramsey, R. J.: Kentucky's Population in the 1960's A County Data Book. University of Kentucky Agricultural Experiment Station Department of Rural Sociology, Resource Development Series 9. Lexington, September, 1963.

5. Stavitsky, A. B.: Micromethods for the Study of Proteins and Antibodies. *J. Immunology,* 72:360-367, May, 1954.

6. Schubert, J. H., and Cornell, R. G.: Determination of Diphtheria and Tetanus Antitoxin by the Hemagglutination Test in Comparison with Test *in Vivo*, *J. Lab. Clin. Med.*, 52:737-743, Nov., 1958.

7. Levin, L., Wyman, L., Broderick, E. J., and Ipsen, J.: A Field Study in Triple Immunization (diphtheria, pertussis, tetanus) Estimation of 3 Antibodies in Infant Sera from a Single Heel Puncture Using Agglutination Techniques, *J. Pediatrics,* 57:836-843, December, 1960.

8. Levine, L., and Wyman, L.: Tetanus Immunity in The North and South, *J.A.M.A.*, 187:518-520, February, 1964.

9. Eckman, L.: Principles on Tetanus. Proceeding of the International Conference on Tetanus. Bern. July 15-19, 1966. Bern and Stuttgart: Hans Huber Publish. p: 245-251, 306-315, 1967.

Botulism—A Case Report

Harold D. Haller, M.D.,* R. T. May, M.D.** and
Richard L. Roth, M.D.***

Louisville, Kentucky

Botulism is a rare disease in Kentucky. The following is a documented case report of type-B botulism from ingestion of home-canned tomato juice. The last laboratory-documented case in Kentucky was in 1964.

BOTULISM comes from the latin *botulus* meaning *sausage*. Botulism is caused by the bacteria *Clostridium botulinum*. It is an anaerobic gram-positive bacillus which produces heat resistant spores. The organism is widely distributed in nature and is frequently found in both terrestial and marine environments. Under suitable conditions which will allow germination of spores a heat labile toxin is elaborated which is one of the most poisonous substances known to man. Toxin production can occur at temperatures as low as 38°F and strict anaerobic conditions are not required.

The disease is rare but often fatal. It is usually due to ingestion of toxin, but has been caused by infection of a wound with *C botulinum* with toxin production *in vivo*[3].

The toxin is a protein neurotoxin. There are six toxigenic types of *C botulinum* recognized on the basis of antigenically distinct toxins produced by different strains of the organism. These are labeled A through F. Four types, A, B, E and F, are the principal causes of disease in man. C and D are usually associated with botulism in birds and mammals. Types A and B cause putrefactive odors when growing in products that are low in acid. Usually gas is produced in canned foods. However, in some vegetable products such as string beans, which head the list of foods involved in outbreaks, growth is slow and the odor may not be sufficient to alarm the person opening the jar. The toxin is elaborated in a precusor form and can be released by treatment with trypsin. After ingestion, the toxin is absorbed causing symptoms simulating denervation. Paralysis is due to the inhibition of acetylcholine at peripheral nerve endings.

*Instructor in Medicine, St. Joseph Infirmary
**Intern, St. Joseph Infirmary
***Instructor in Neurology, St. Joseph Infirmary

Case History

This 53-year-old W/M was admitted to St. Joseph Infirmary on March 13, 1969, with a chief complaint of difficulty in swallowing for four days and diplopia. Seven days previously on the evening of March 6, 1969, he had broken the seal on a jar of home canned tomato juice, taken one drink and realized it had a sour taste. The remainder of the contents were discarded and the jar was cleaned, this being the last of a batch of 28 jars. The remaining 27 jars had all been consumed. He was well until the following day at work when he felt nauseated after eating a bowl of split pea soup, milk and cherry pie. He went home that evening where, throughout the night, he had several episodes of nausea, vomiting and cramping abdominal pain.

On the following morning he was seen in his home by his family physician. He had a normal physical examination and was given Phenergan I.M. for his vomiting. The vomiting and abdominal pain subsided but by the third day after ingestion of the tomato juice he experienced intermittent episodes of diplopia. However, the extraocular muscles were intact and fundiscopic examination was normal. On the fourth day he had continuous diplopia, dysarthria, dysphagia and fatigue. The symptoms remained the same until March 13, 1969, at which time he was seen by his family physician and had a definite third nerve and sixth nerve palsy. It was then that the history of the spoiled home-canned tomato juice was obtained and the patient was admitted to the hospital.

Past History

He had undergone surgery for removal of a benign nasal polyp five years previously and

TABLE 1

Results of tests for botulinum toxin and/or Clostridium botulinum performed on materials related to a case of botulism hospitalized in St. Joseph Infirmary during the week of March 14, 1969.

NCDC*	Specimen	Results
52-5306	Blood (collected 3/13/69)	(1) Type B botulinum toxin detected (2) No C. botulinum organisms isolated.
52-5349	Empty dry jar which had contained tomato juice consumed by patient	No. C. botulism organisms isolated.
52-5350	Blood (taken after patient received botulinum antitoxin)	(1) No botulinum toxin detected. (2) No C. botulinum organisms isolated.
52-5355	Feces, collected 3/17/69	C. botulinum type B isolated.
52-5485	Feces, collected 3/18/69	C. botulinum type B isolated.
52-5447	Feces, collected 3/22/69	No C. botulinum isolated.
52-5385	Blood, collected 3/15/69	Not examined. Serum frozen for further studies if needed.

*NCDC (National Communicable Disease Center, Atlanta, Georgia)

had been on antihypertensive medication for four years. Otherwise, the past history was non-contributory.

Physical Examination

Vital signs: T - 97.2, P - 68, R - 16, B.P. 130/95.

General conditions: This was a well developed W/M in no acute distress, oriented but with obvious dysarthria.

Positive physical findings: The lips, tongue, oropharynx, soft palate and posterior pharynx were dry and parched. The tongue was dry, edematous and fissured. There was a thick white exudate on the posterior pharynx. Neurologic examination revealed symmetrical weakness of all extraocular muscles. There was bilateral and symmetrical facial weakness. The gag reflex was markedly diminished. There was symmetrical weakness of the sternomastoid museles, trapezius muscles, and weakness of the shoulder girdle muscles. Knee jerk and ankle jerk reflexes were 1 + and symmetrical. No Babinski or Hoffman reflexes were present. No sensory defects were present and neither gait nor coordination were affected.

Laboratory findings: Hgb - 13.8, Hct - 40.0, WBC - 7,000 with a normal differential. Urinalysis was normal. Chest x-ray showed an aetive pneumonic process at the left lung base. Skull x-rays, spinal fluid examination, serum electrolytes and ECG were all normal. On the night of admission and subsequent days thereafter, blood and stool speeimens were obtained and sent to the National Communicable Disease Center in Atlanta, Georgia. These results are found in Table 1.

Hospital Course

On the date of hospital admission, March 13, 1969, the patient received 10,000 units of bivalent botulism antitoxin I.V., was given I.V. fluids and begun on 1.2 million units of procaine penicillin daily. On March 15, 1969, word was received from Atlanta that the patient's sera contained type-B Botulism toxin. He then received another 10,000 units of bivalent antitoxin I.V. He began to show marked objective and subjeetive improvement about six hours following the seeond 10,000 units of antitoxin. He reeeived 10,000 units of antitoxin on Mareh 17, 1969, but demonstrated little change following this administration.

On the sceond hospital day he demonstrated postural hypotension. His sitting systolic B.P. was 60 mm. Hg., supine B.P. 118/80. At the time of discharge, nine days after admission, his diplopia had cleared, he had a full range

of extraocular movements, his dysarthria had nearly cleared and his dysphagia was improved. However, his mouth and pharynx were still very dry and he still had postural hypotension.

Discussion

Although botulism is a rare disease it should always be considered in any food poisoning associated with symmetrical motor neurological deficit in the absence of sensory deficit. This may occur up to eight days after the ingestion of contaminated food.

This is the first documented case of botulism being acquired from tomato juice. We usually think of botulism associated with alkaline foods, the classic example being green beans. However, botulism has been documented from a variety of foods. An important fact in this case is that *C botulinum* was cultured from the stool 12 days after its ingestion. There is some controversy as to the efficacy of penicillin in the treatment of botulism. If the organism can be cultured from the stool after this length of time, the likelihood of *in vivo* toxin production seems very real and penicillin therapy seems indicated.

Hypotension has been reported in botulism but only once in 56 outbreaks. This patient demonstrated marked postural hypotension even though he was previously hypertensive.

Ten weeks after the ingestion of the home-canned tomato juice this patient's symptoms cleared completely. The last symptoms to clear being dry mouth and dyphagia.

Acknowledgements

We would like to thank the N.C.D.C. in Atlanta for their advice and laboratory assistance in this case. We would also like to thank the Kentucky Department of Public Health for their help and foresight in having antitoxin available.

References

1. "Botulism in the United States"—U.S. Department of Health, Education and Welfare.

2. Maxcy—Rosenan: *Preventive Medicine and Public Health*, ninth ed., Appleton—Century Crafts, New York, 1965, p. 416.

3. Petty, C. S., 1965 Botulism: The disease and the toxin. *Am. J. Med. Sci.* 249: 345-359.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

An Unusual Complication in Permanent Cardiac Pacemakers

GARY B. GARISON, M.D.* AND R. L. RAINEY, M.D.**
Louisville, Kentucky

Two patients with unusual permanent pacemaker complications are presented. Their course and management are described with recommendations for management of failing units.

SINCE 1952 when Zoll[1] first described the method of electrical pacing of the heart in patients with complete heart block, many changes have occurred in the methods, equipment and indications for pacing. External precordial pacing still plays an important role in the management of patients with complete heart block, especially as a stand-by system to prevent recurrence of Stokes-Adams attacks until a temporary or permanent battery unit can be employed. Associated with the advent of catheter pacing, both temporary and permanent, has been the occurrence of associated complications such as wire breakage, ventricular perforation, rising threshhold, electrode displacement, infection and induced arrhythmias such as ventricular tachycardia and fibrillation[2, 3, 4, 5]. It is the purpose of these two case reports to describe unusual complications in two patients with failing permanent pacemaker units. In the first case reported, pacing persisted after transection of both electrodes and the implanted, failing unit eventually had to be removed to prevent its pacing. In the second case, pacing persisted after a segment of one lead was removed and ceased only when a segment of the second lead also was removed.

Report of Cases

Case #1: A 74-year-old white female was admitted to the Louisville General Hospital in February, 1964, with congestive heart failure and was found to have complete heart block with a slow ventricular rate. In November, 1966, because of refractory congestive failure associated with a slow ventricular rate, an Electrodyne pacemaker was implanted in the subcutaneous tissue of the left chest wall with the pacing electrodes sutured to the left ventricular wall.

She then did well until readmission in April, 1968, with shortness of breath. Evaluation revealed a failing pacemaker with a variable rate of 0 to 200. An attempt to place a temporary transvenous unit was unsuccessful. Therefore, the pacemaker leads were located, separated from the failing unit, and connected to a temporary pacemaker and she paced normally. The original, permanent Electrodyne unit was left in place for later removal.

The following morning a regular tachycardia of 150 was noted on the monitor. A rhythm strip was obtained which showed a regular pacing spike at a rate of 72 per minute but, in addition, a smaller spike at a rate of 150 per minute which was initiating the ventricular responses. A permanent transvenous unit was then inserted per the right subclavian vein and the failing unit was removed. The patient then did well.

Case #2: A 71-year-old white male had a myocardial infarction in January, 1966. In April, 1966, EKG revealed second and third degree heart block and he had concomitant congestive heart failure. In May, he developed persistent third degree A-V block and had a transthoracic pacemaker inserted and was subsequently readmitted in June, 1966, for pacemaker failure caused by a broken electrode wire.

In October, 1966, pacemaker failure occured and a new pacemaker was inserted. He was again admitted to the Jewish Hospital in Louisville in November, 1967, with an irregular rhythm produced by a failing pacemaker.

*Fellow in Cardiology, Cardiovascular Laboratory, University of Louisville, Louisville, Kentucky
**Chief of Cardiology, Cardiovascular Laboratory, University of Louisville, Louisville Kentucky

At that time a subcutaneously implanted Electrodyne unit with electrodes sutured into the left ventricular myocardium was present. A temporary transvenous unit was inserted and he paced well.

However, shortly thereafter a rapid rate was noted intermittently on the monitor, sometimes attaining a ventricular rate of 150 and competition was noted to be occurring between the temporary and the previously implanted permanent unit. One of the leads from the permanent unit was then localized and a segment several inches in length was removed and competition ceased. A short time later, however, competition with a rapid ventricular response was again noted and ceased only when a segment of remaining intact permanent electrode lead was removed.

Comment

To the best of our knowledge, continued pacing after both epicardial electrode leads have been cut has not been previously reported and continuation of pacing after removal of a segment of one electrode wire is rare. The first case demonstrates the ability of an implanted pacemaker to pace the ventricles after transecting both epicardial electrodes near their point of junction with the power unit. Since this pacemaker unit paced the heart from its subcutaneous, extrathoracic, inframammary implantation site, it constituted a form of external pacing. The second case demonstrates unipolar pacing after excision of a segment of one epicardial electrode, the exposed proximal segment of which then makes contact with the subcutaneous tissue and acts as an indifferent electrode. In the past, the usual recommendation for stopping further pacing of the heart by a failing unit has been to cut both electrode wires or to excise a segment of one electrode lead. The former has been considered a sure means of interrupting pacing while the latter rarely fails to stop pacing provided the proximal tip of the transected electrode wire is not left bare.

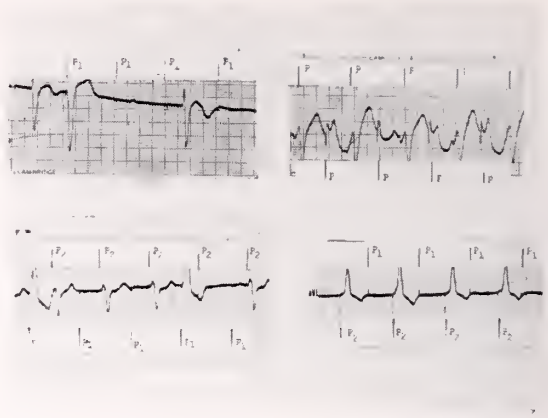


FIGURE 2. Strips in sequence left to right starting upper left. Strip 1: Complete heart block with idioventricular rhythm with rate of 34, failing pacemaker spikes (P_1) occasionally cause ventricular activation. Strip 2: Two functioning pacemakers (temporary unit and failing unit) denoted by (P's) both of which are causing ventricular activation at a rate of 150/min. Strip 3: Competition between the temporary and permanent pacemakers after removal of a segment of one electrode of the permanent unit. Strip 4: Temporary pacemaker P_2 activating ventricle; permanent unit spike present but not activating ventricle since a segment from both permanent electrodes had been removed.

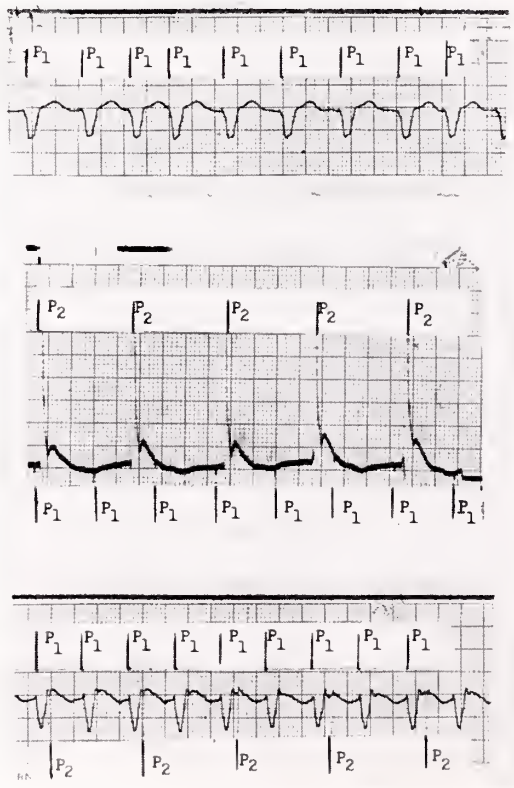


FIGURE 1: First strip shows rapid, irregular ventircular rhythm due to runaway pacemaker, pacing spikes denoted by P_1. Second strip shows regular ventricular pacing at a rate of 75 by temporary unit P_2; failing implanted unit spikes P_1 are seen but are not activating ventricle. Third strip shows rapid, regular ventricular pacing at a rate of 150 caused by failing unit P_1; temporary unit spikes P_2 are present but not pacing.

The present cases illustrate the possibility of continued pacing of the ventricles despite transection of one or both electrode leads of a failing pacemaker. Since many patients with a failing power pack would first have a temporary transvenous electrode catheter inserted for pacing from an external battery pacemaker, the strong possibility of competition from

(Continued on Page 866)

Hemangioma of Spinal Canal

LASZLO MAKK, M.D.* AND GORDON L. SMILEY, M.D.**
Louisville, Kentucky

A patient is described with recurring upper back pain that was produced by extradural spinal canal hemangioma at T5-T6 level. The diagnostic procedures, surgical pathology and treatment of these lesions are discussed.

THE majority of spinal cord neoplasms are in man and are metastatic lesions[1]. Hemagiomas of the spinal canal occur quite rarely. A survey disclosed four per cent of spinal cord tumors to be vascular in nature[2]. In contrast to the rarity of hemangiomas located in the spinal canal, hemangiomas of the vertebral body occur relatively frequently and they also may produce compression symptoms with extension.



FIGURE 1. Myelogram demonstrated complete block at T5-T6 level.

History

The patient sought medical advice because of pain in his right torso and upper back. He was a 52-year-old carpenter, who had experienced episodes of right-sided lancinating, mid-dorsal circumthoracic pain for two years. These episodes occurred twice each year and persisted for six or seven days. Intense paroxysms of pain were induced by coughing, sneezing and bending. Pain radiated from the right mid-dorsal paraspinous area in the fifth or sixth dorsal segment, extending around the right chest and through the chest into the right anterior costal margin. When he was first seen by his attending neurosurgeon, the pain was so intense that he was unable to lie down, sit or stand comfortably for more than a few moments.

Physical Examination

The general physical examination was non-contributory. On neurological examination, there was no numbness or paraesthesia or weakness about the trunk or lower extremities. Bowel and bladder functions were not impaired. There were no significant abnormal findings in the rest of the neurological examination.

Course in the Hospital

Roentgenograms of the dorsal spine appeared normal. Myelography revealed a complete subarachnoid block of extradural type at the T5-T6 level and suggested a posterior location. (Fig. 1) Laminectomy of T5-T6 disclosed a posteriorly situated, reddish brown, firm, encapsulated, extradural tumor of cylindrical shape, approximately 3-4 cms. in length and 2 cms. in diameter and having a lump on its right side extending into the intervertebral foramen. The tumor had many nutrient vascular strands attaching it to the walls of the spinal canal. It was easily detached from the dural sheath and was totally removed. The right fifth nerve root was sectioned.

The postoperative course was uncomplicated. His intense radicular pain was complete-

**Pathologist, St. Anthony Hospital, Louisville, Kentucky*

***Neurosurgeon, Louisville Kentucky*

ly relieved. There was mild segmental sensory impairment about the right hemithorax. There was no evident trauma to the spinal cord. He ambulated on the fourth postoperative day and was discharged from the hospital on the seventh day, much improved.

Tissue Examination

The specimen is a maroon-colored bilobated soft tissue 30x19x6 mms. at the present state. On one surface there appears to be a delicate capsule. The other surface is rough. In one area there is a firmer part of the tissue and it is mixed with striated muscle fibers. Microscopic sections prepared from the entire material display in the fibrous stroma numerous endothelium lined spaces. Many of these spaces vary in size and shape. The endothelium does not display any atypical proliferation anywhere. There is a fine fibrous capsule on part of the surface (Fig. 2).

Tissue Diagnosis: Extradural space, hemangioma at T5-T6 level.

Comment

The differential diagnosis of these symptoms in this patient's age group includes a large scale of disorders from angina and dissecting aneurysm to bursitis. Occasionally, a rare lesion, such as in the present instance, may tax the diagnostic acumen of the examiner.

The most valuable diagnostic procedure is myelography. For the evaluation of the extent of this lesion, angiography is recommended. Laminography of the dorsal spine is helpful for the evaluation of vertebral involvement[3].

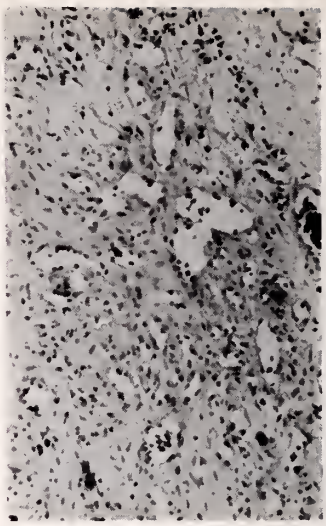


FIGURE 2. Tissue section display varying size endothelium-lined spaces separated by loose fibrous stroma.

Most of these lesions constitute arterial-venous shunts. In many of them, there are no intermediate capillaries and in others they are present between the arteries and veins. In this case, they were present. The treatment of choice is excision. In cases where the lesion penetrates through the dura and excision is not possible, ligation of the feeding arteries usually produces beneficial results. Arteriographs might be of considerable help in the localization of these arteries.

References

1. Harer, A. F., M. D. and Smith, R. R., M. D., Neoplasms involving the Spinal Cord: An Analysis of 85 consecutive cases, *Southern Med. J.* Vol. 61, 801-807, 1968.
2. Long, D. M., M. D., Ph.D., Spinal Cord Compression Secondary to Neoplasms, *Minnesota Med. J.* Vol. 51, 1239-1244, 1968.
3. Houdart, R., M. D. and Djindjian, R. M. D., Angiomas of the Spinal Cord, *Proc. Royal Soc. of Med.* Vol. 59, 787-790, 1960.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time...
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband...
and for herself as well...
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.



Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestagen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began
G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

SO 8-5117 B

What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201





House Takes Action On Usual And Customary

WALTER S. COE, M.D.*

THE Usual and Customary program for health insurance adopted by the KMA House of Delegates in September, 1968. received considerable discussion throughout the year. While various aspects of this program were discussed periodically in The Journal, a portion of the membership questioned whether or not adequate information had been disseminated. Some felt that members of the 1968 House of Delegates did not realize that the Usual and Customary program they were voting on was a paid-in-full program.

Numerous resolutions and reports on this subject were presented to the 1969 session of the House of Delegates so that a clarification could be made. For the information of all KMA members, the following report was adopted by the House of Delegates in session on September 24, 1969.

"The KMA Board of Trustees has received a communication from the Fayette County Medical Society questioning whether or not the Usual and Customary concept previously adopted in 1968 by the House of Delegates is, in fact, a paid-in-full program. After reviewing last year's report of the KMA Advisory Committee to Blue Shield and the information disseminated to Kentucky physicians since its approval, it is the opinion of this committee that this does represent a paid-in-full program for covered services.

1. The public is rapidly increasing its demands for paid-in-full type surgical-medical programs which will permit an individual to prepay for the full cost of covered services.

2. It is the official policy of the National Association of Blue Shield Plans that all individual Blue Shield Plans must have available this type of Usual and Customary program.

3. The American Medical Association officially endorses and promotes the Usual and Customary concept for payment of physicians fees by all third parties; and that, any reference to paid-in-full coverage clearly identify those services which are indeed covered on a paid-in-full basis and also identify the circumstances under which those services must be rendered to all third parties.

4. Without the paid-in-full concept, Usual and Customary has no meaning other than that of being just a high-priced indemnity program which cannot be sold in the marketplace.

5. In order to make the program operative, certain requirements are necessary. This committee recommends that the Usual and Customary and paid-in-full concept be one and the same with the following requirements recognized:

a. Physicians can signify their support of the Usual and Customary concept by being a 'participating' physician and by signing an agreement to that effect.

b. A physician who does not accept this concept could elect to not sign a participating physician agreement.

c. Participating physicians would agree to accept as payment in full allowances made by Blue Shield's Usual and Customary program for covered services using guidelines established by the KMA Claims Review Committee. Peer review committees, which are a part of these guidelines, will make the final recommendations for reasonable allowances

*Editor, KMA Journal

on cases that cannot be processed routinely. Payments will be made direct to the participating physician.

d. Blue Shield's allowances for covered services rendered by non-participating physicians will be determined using the same guidelines as for participating physicians except payment for covered services will be made direct to the subscriber.

e. A peer review committee with the assistance of Blue Shield shall review physicians' fees at least annually to insure such fees will not remain fixed but will adjust with the economy.

6. It is recommended that the KMA Board of Trustees, working in cooperation with Blue Shield, institute an immediate and continuing multi-phasic program of education to assist the profession and the public in the explanation and implementation of the Usual and Customary program.

7. It is further recommended that the Board of Trustees reaffirm the position taken by the 1968 House of Delegates and that it urge the Blue Shield staff to continue marketing the Usual and Customary program under the present guidelines, working toward obtaining individual participating physicians' agreements."

Medical Credit Cards†

THERE has been much discussion in medical circles lately, concerning the use of medical credit cards and there are a number of organizations, including banks, becoming involved in this area of activity. The Executive Committee of the KMA Board of Trustees on September 4 adopted the principles of the AMA Judicial Council that are applicable to the use of medical cards and requested that these principles be brought to the physician's attention through the KMA Journal.

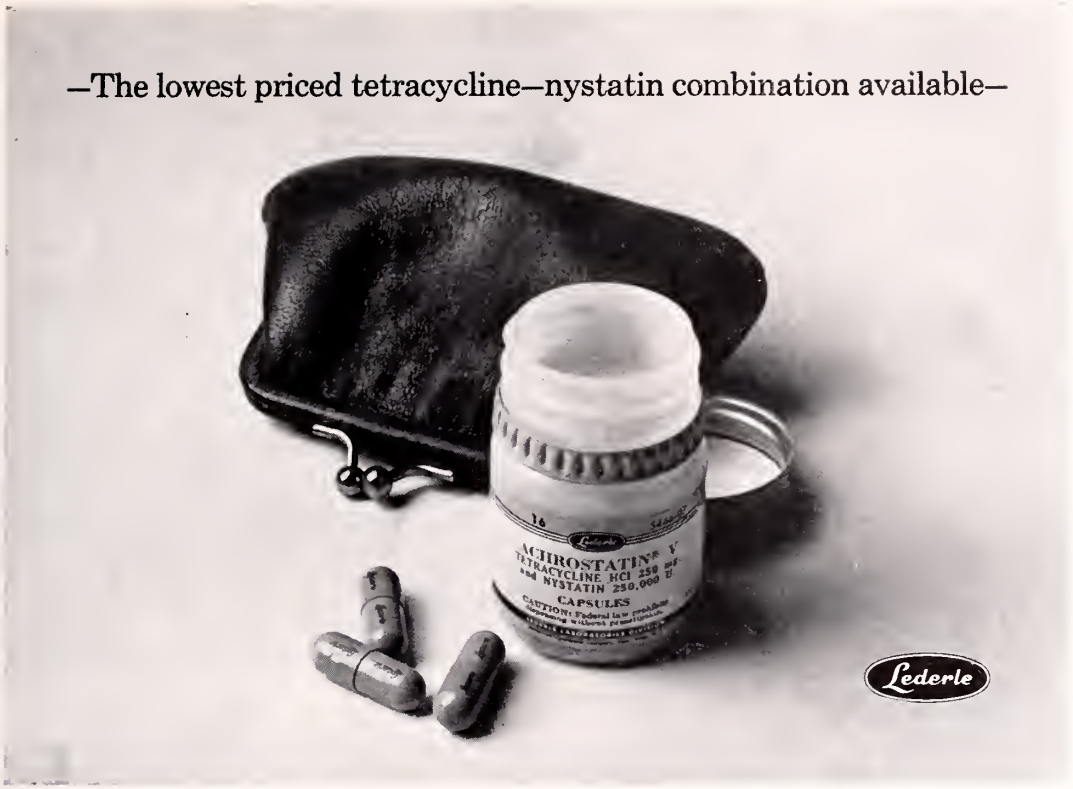
"(1) The county medical society should be satisfied as to the financial and professional integrity of the plan. It should negotiate with the plan sponsors to insure that service charges to the physician are reasonable. It should insist that the plan be open to all physicians on the same terms and that it not exploit or capitalize on physicians' participation in the plan. It should advise the plan that the listing of physicians in directories of participating members is contrary to the ethics of the medical profession.

(2) The individual physician may not, because of his participation, increase his fee for medical service rendered the patient. He may not use the plan to solicit patients. He may not encourage patients to use the plan. His position must be that he accepts the plan as a convenience to patients who desire to use it. Plaques or other devices indicating participation in the plan within the physicians office shall be kept to a discreet and dignified minimum. Plaques, signs, or other devices indicating such participation visible outside the physician's office are unacceptable.

(3) The use of a bank card in connection with the payment of larger fees—which might normally be paid to the physician in installments—is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges. Out of respect for the dignity and traditions of the medical profession, the physician may not relieve himself of his obligations 'to render service to humanity, reward or financial gain being a subordinate consideration.' "

†*This article was prepared at the request of the Executive Committee of the KMA Board of Trustees.*

—The lowest priced tetracycline—nystatin combination available—



★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

NOVEMBER

6 L. E. Smith Lecture, University of Kentucky Medical Center, Lexington

6-7 Third Annual Newborn Symposium, Department of Pediatrics, University of Louisville School of Medicine, Louisville

7-8 Kentucky Thoracic Society, Fall Scientific Session, Boone Tavern, Berea

12 PANMED television series, "Psychotomimetics And Their Abuse," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

13-14 Recent Developments in the Surgical Care of Trauma Program, University of Kentucky Medical Center, Lexington

17 PANMED television series, "Psychotomimetics And Their Abuse," in Louisville, WKPC-TV, 10 p.m.

19 PANMED television series, "Organizing For Effective Management," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

24 PANMED television series, "Organizing For Effective Management," in Louisville, WKPC-TV, 10 p.m.

26 PANMED television series, "In a Medical Laboratory," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

DECEMBER

1 PANMED television series, "In A Medical Laboratory," in Louisville, WKPC-TV 10 p.m.

3 PANMED television series, "Surgical Endodontics," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

8 PANMED television series, "Surgical Endodontics," in Louisville, WKPC-TV 10 p.m.

10 PANMED television series, "Almost A Miracle," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

15 PANMED television series, "Almost A Miracle," in Louisville, WKPC-TV 10 p.m.

17 PANMED television series, "Drug-Drug Interaction Affecting the Patient," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

19-20 Postgraduate course, Practical Ophthalmology for the Generalist, University of Kentucky Medical Center, Lexington

22 PANMED television series, "Drug-Drug Interaction Affecting the Patient," in Louisville, WKPC-TV 10 p.m.

JANUARY

7 PANMED television series, "Clinical Use of Electrical Pacemakers," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

12 PANMED television series, "Clinical Use of Electrical Pacemakers," in Louisville, WKPC-TV 10 p.m.

14 PANMED television series, "Newer Psychotherapeutic Agents: The Antidepressants," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

19 PANMED television series, "Newer Psychotherapeutic Agents: The Antidepressants," in Louisville, WKPC-TV 10 p.m.

29-31 Symposium on Modern Methods for the Medical Work-Up, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

NOVEMBER

10-13 Southern Medical Association, 63rd Annual Meeting, Atlanta, Ga.

12-13 Postgraduate course, "Diseases of the Small Intestine and Colon", Cleveland Clinic Educational Foundation, Cleveland.

12-15 Third Annual Postgraduate Conference on "Today's Hospital Problems: An Interdisciplinary Approach", Tides Hotel and Bath Club, Redington Beach, Florida.

21-22 Delivery of Medical Care in the 1970's workshop, The Institute of Medicine of Chicago, Ambassador West Hotel, Chicago

DECEMBER

3-4 Postgraduate course, "Respiratory Failure—Acute and Long Term Management," Cleveland Clinic Educational Foundation, Cleveland

6-11 Annual Meeting, American Academy of Dermatology, Bal Harbour, Florida

10-11 Postgraduate course, "Concepts in Diagnosis and Management of Diseases of Vitreous, Retina and Choroid," Cleveland Clinic Educational Foundation, Cleveland

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

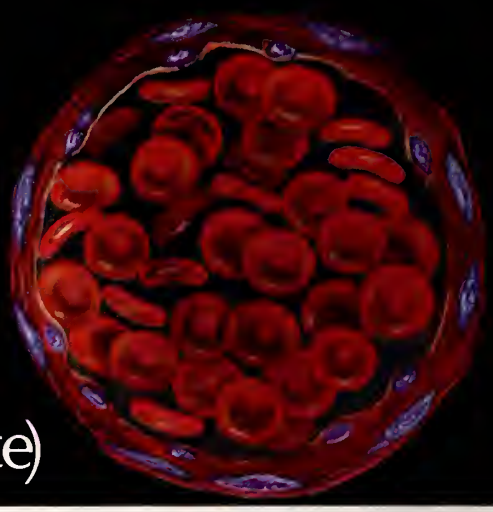
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



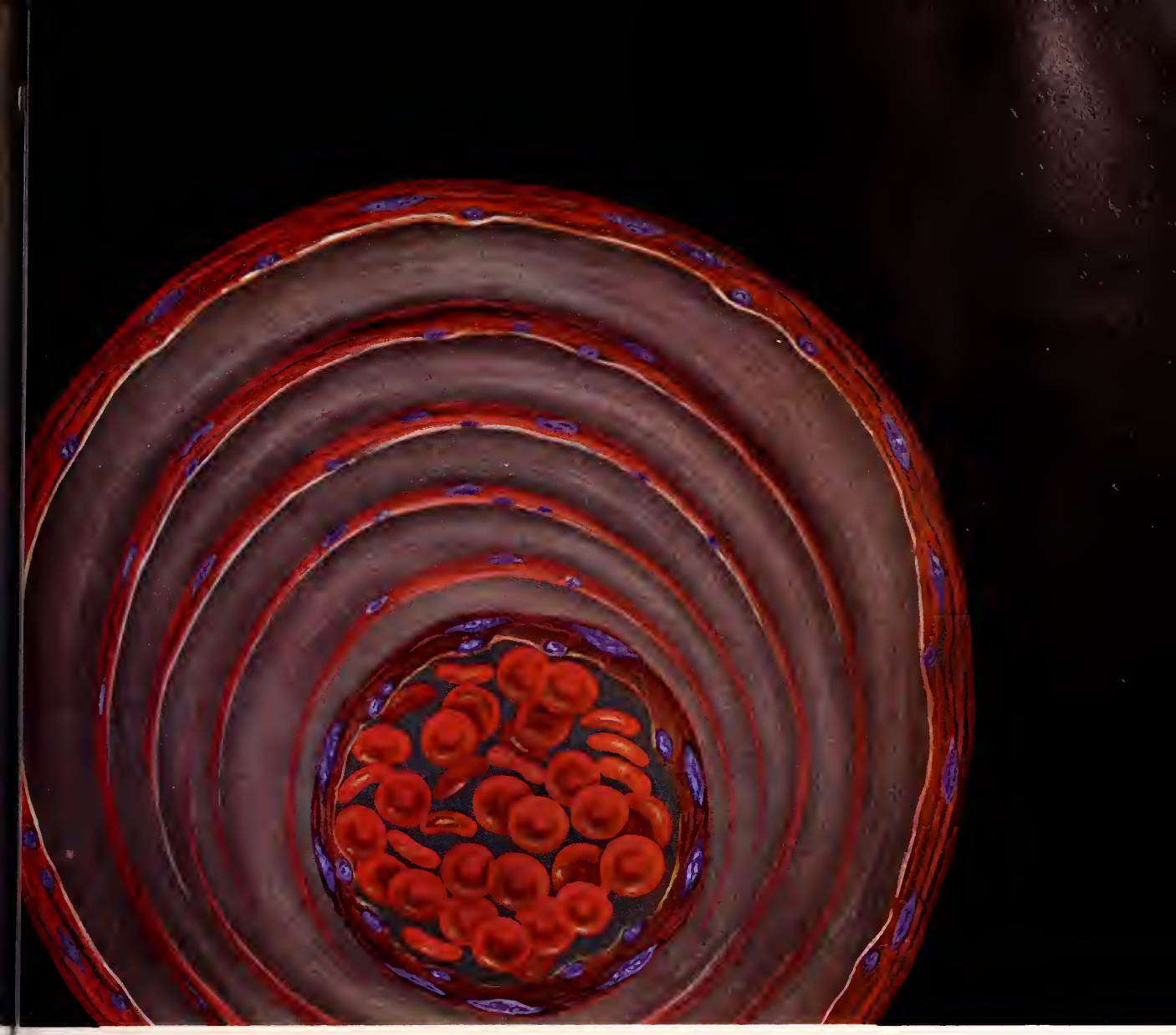
Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided sustained-release Roniacol Timespan (nico alcohol tartrate) Tablets. Part of the drug b comes available immediately, the remaind continuously over a period of up to 12 hou and dilation of constricted peripheral vesse usually maintained. Thus, with a single dos medication, patients can enjoy the benefits increased peripheral blood flow in ischemi extremities for up to 12 hours.



mooth peripheral vasodilation from initial osage...extended with mple, well-tolerated, b.i.d. dosage

e prolonged action of Roniacol Timespan cotinyl alcohol tartrate) together with its ıer benefits offer a therapeutically practical asure in the long-term management of ·ipheral vascular disease–advantages ɔecially important for older patients.

·ore prescribing, please consult complete ɔduct information, a summary of which lows:

lications: Conditions associated with ·icient circulation; e.g., peripheral vascular ease, vascular spasm, varicose ulcers, cubital ulcers, chilblains, Meniere's syn-ɔme and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.


Food 'n mouth disease

eludin® phenmetrazine hydrochloride

eludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

ontraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

/arning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

Preludin may be used to curb appetite in obesity associated with such conditions.

For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-evening suppression of appetite.

Preludin® phenmetrazine hydrochloride Endurets® prolonged–action tablets

R-6611



Everett H. Baker, M. D.
1903-1969

Everett H. Baker, president of the Kentucky Medical Association in 1965, died September 18, in Louisville, Kentucky. Doctor Baker was born in the year 1903—in Louisville. He graduated from the University of Louisville School of Medicine in 1925 and interned in what was then called the Louisville City Hospital. He practiced medicine in Louisville from 1927 to 1942. He served in the Army Air Force from 1942 to 1946.

After completion of his military service, Doctor Baker took postgraduate work in anesthesiology. He became assistant professor of anesthesia at the University of Louisville in 1947. He was president of the Kentucky Society of Anesthesiologists in 1948 and president of the Louisville Society of Anesthesiologists in 1958. He was a past president of the medical staff of St. Joseph Infirmary. In 1955 he was vice president of the Kentucky Medical Association and in 1961 was president of the Jefferson County Medical Society.

Although Doctor Baker was active in many medical organizations—and had been president of many of them—he found time to participate in other community activities. He taught Sunday School at the Beechmont Methodist Church in Louisville for many years and was also chairman of the Board of Stewards of that church. He enjoyed his hobbies of music, farming and tennis. He will long be remembered for his leadership abilities, his good humor—and his many contributions to Kentucky medicine.

EDITORIALS

Proposed Changes For The Board of Health

THE members of KMA are generally aware that some changes in the structure and functions of the State Board of Health have been proposed. In 1965-66 the Governor's Commission on Economy and Efficiency pointed out that there is much fragmentation and overlapping of health services in our state government which, if corrected, should bring about better and less expense of operation. KMA formed a committee headed by Gabe A. Payne M.D., to study these claims and to recommend needed improvements. The information gathered by this committee has been made available to the physician members of the subsequently-created Comprehensive Health Planning Council which is carrying on a continuing study of the various means by which health services are being provided to our people.

The 1968 General Assembly authorized the Kentucky Legislative Research Commission to study the structure and functions of all Boards in the state government. Research Report No. 53 compiled by John D. Hinkle dealing with the State Board of Health was released in July, 1969. This report was immediately made the subject of careful study by all members of the Board of Health and of the Executive Committee of KMA separately and jointly and a proposal was presented by Robert C. Long, M.D. before a Public Hearing of the Research Commission in Frankfort on September 12, 1969, outlining a plan for enlarging the State Board of Health.

Our State Board of Health was established in 1878 as a means of controlling epidemics and providing more healthful conditions for the entire state. It consisted of the State Health Officer and six physicians appointed by the Governor. Its composition has changed little since the beginning; there are now seven physicians in addition to the Commissioner and a dentist and pharmacist-a total of ten members. Since 1904 additional functions of the Board have been to examine prospective physicians, issue them certificates or licenses to practice, and to exert disciplinary control of practicing physicians. These are basically the functions of the Board today.

Our Board is classified in the Research Commission's report as administrative rather than advisory. It is in fact administrative in matters pertaining to licensure and discipline of physicians, but it functions in a general advisory capacity to the Commissioner in matters relating to the Department of Health. It should properly be listed, therefore, as both administrative and advisory in its function. In this role it has performed a highly satisfactory service to the state for the past 70 years.

In recent years there has been an increasing opinion that the State Board of Health should include in its structure representation from other professions than medicine, specifically nursing, engineering, hospital administration, veterinary and from general consumers of health services. It is felt by many that a broader participation in the establishment of policies relating to the health of our people is more appropriate and will be constructive. Measures have been introduced in recent legislatures to this end and have gained considerable support. The idea is strengthened by the wide participation of lay people in such health related organizations as the Heart Association, Cancer Society and Rheumatism Foundation.

Furthermore, many State Boards of Health have included in their structure members from other health related professions than medicine and consumers of health services.

The Legislative Research Commission in its report supported this concept. Members of the Board of Health and trustees of KMA find some merit in such a proposal and have given it endorsement with one important reservation. The matter of medical licensure and monitoring the conduct of physicians is a function which should be separated from such an expanded Board and conducted by physicians only. As a matter of fact, it is a function separate from the Board of Health in every state except three—Kentucky, Alabama and Mississippi.

It was, therefore, recommended jointly by the Executive Committee of KMA and the State Board of Health that a separate Board of Medical Licensure be established composed entirely of physician members.

It is proposed now that the newly constituted Board of Health be constructed in the following manner: the Commissioner of Health and Commissioner of Mental Health—ex officio members without voting power; seven physician members appointed by the Governor upon recommendation of the KMA; one dentist, one pharmacist, one veterinarian, one registered nurse, one hospital administrator, one sanitary engineer, each appointed by the Governor upon recommendation of the appropriate association from which the member is selected; two members selected and appointed by the Governor from the general public—the "Consumers of Health Services."

The Commissioner of Health is at present appointed by the State Board of Health. Since the Commissioner is a member of the Governor's official Cabinet, it is thought better that we suggest his appointment by the Governor after his selection and recommendation by the State Board of Health.

Fragmentation of health services is a problem of major concern to all and has been under study by the agencies noted in the beginning. Some progress is being made in this but reconstruction of the Board of Health seems to be the principal immediate objective and will probably be the subject of proposed legislation next year. It was thought appropriate to keep the membership informed regarding the proposals recently presented as a basis for future plans.

SAM A. OVERSTREET, M.D.

Watch for in the December Journal —

— Digest of Proceedings, 1969 House of Delegates Meeting

— KMA Constitution and Bylaws

— 1969 Journal Index



introducing an anticostive* antacid

*Avoids constipation.

Gelusil-M avoids constipation

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing

NEW

GELUSIL®-M

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide
*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patien



Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquic

Pleasant mint flavor...ideal for hospi tal or home. Available in 12 fl. oz. an 6 fl. oz. bottles and a special hospita pack. An antacid which contains adsor bent and demulcent agents in each ml. teaspoonful: 0.25 Gm. aluminun hydroxide (Warner-Chilcott), 0.5 Gm magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)– or more—between meals and at bed time, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey
GM-IN-92-4C

ORGANIZATION SECTION

House Elects Dr. Quertermous, Dr. Hull At Annual Meeting

John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board of Directors, was elected by the House of Delegates as president-elect for the 1969-70 Associational year.



Doctor Quertermous

Also elected at the September 24 session was David A. Hull, M.D., Lexington, who is the Association's new vice-president.

Walter L. Cawood, M.D., Ashland, was installed as KMA President at the close of the session, succeeding Henry B. Asman, M.D., Louisville.

Doctor Quertermous, a 1942 graduate of the University of Louisville School of Medicine, interned in Cincinnati and then served in the U.S. Army during World War II. After taking his residency in internal medicine in Louisville, he went into private practice at Murray in 1950. Doctor Quertermous has been an AMA delegate since 1963 and is a former chairman of the KMA Council on Legislative Activities for national affairs.



Doctor Hull

Succeeding Edwin P. Solomon, M.D., Louisville, Doctor Hull is a member of the Legislative Committee and president of the Fayette County Medical Society.

Elected AMA delegate for the term January 1, 1970 to December 31, 1971 was George F. Brockman, M.D., Greenville. Incumbent Charles C. Rutledge, M.D., Hazard, was elected AMA delegate for the same term. Alternate AMA delegate incumbents, Daryl P. Harvey, M.D., Glasgow and David B. Stevens, M.D., Lexington, were also elected to the same term.

Dr. Hall Named Board Chairman Vice Chairman Is Dr. Bryan

The KMA Board of Trustees, at its first meeting on September 25, elected William W. Hall, M.D., Owensboro, to serve as its chairman for the Associational year 1969-70. Thornton E. Bryan, Jr., M.D., Cadiz, was named vice chairman of the Board.



Doctor Hall



Doctor Bryan

Doctor Hall, beginning the third year of his first term as trustee for the Second District, succeeds Lee C. Hess, M.D., Florence.

A general practitioner in Owensboro since 1959, Doctor Hall graduated from the University of Louisville School of Medicine in 1954 and took his residency at the Georgia Medical Center. He is a former president of the Daviess County Medical Society, a former alternate AMA Delegate and the past insurance editor for The KMA Journal.

Doctor Bryan is also a 1954 graduate of the University of Louisville School of Medicine and is doing general practice in Cadiz. Beginning his second year in his first term as KMA trustee of the Third District, Doctor Bryan is a former president of the Kentucky Academy of General Practice and a member of the advisory council to the Pennyrile Regional Medical Program.

E. C. Seeley, M.D., London, was elected by the House to a third term as trustee for the Fifteenth District. Harold L. Bushey, M.D., Barbourville, was re-elected as alternate trustee of this district.

Elected to a second term as trustees were Doctor



As the first official duty of the new KMA president, Walter L. Cawood, M.D., Ashland, presents a plaque for outstanding service to the Association to the outgoing president, Henry B. Asman, M.D., Louisville. The presentation was made at the close of the final session of the House, September 24.

Hess, trustee for the Eighth District, and Douglas H. Jenkins, M.D., Richmond, trustee for the Eleventh District. Alternate Hugh Mahaffey, M.D., Richmond, was re-elected for the Eleventh District.

Trustees and their alternates elected for the first term on the Board are John S. Llewellyn, M.D., Louisville, and alternate Lloyd G. Yopp, M.D., Louisville, Fifth District; Paul J. Parks, M.D., Bowling Green and alternate Carlisle V. Dodson, M.D., Russellville, Sixth District; and Carl J. Brueggemann, M.D., Covington, elected alternate to the Eighth District.

Nominating Committee Chosen

The Nominating Committee members, who will select the 1970-71 officers of the Association, were elected by the KMA House of Delegates at its final session September 24.

The five committee members chosen were W. E. Becknell, M.D., Columbia; Clyde Brassfield, M.D., Elizabethtown; Thomson R. Bryant, M.D., Lexington; W. Faxon Payne, M.D., Hopkinsville, and W. Fielding Rubel, M.D., Louisville. The committee will select one of its members as chairman at its first meeting during the Interim Meeting April 8 and 9 at Kentucky Dam Village.

KEMPAC Physicians Hear Views Of Two U.S. Senators At Seminar

U. S. Senator George Murphy, R-California and U. S. Senator Birch Bayh, D-Indiana joined Rex Kenyon, M.D., chairman of the Oklahoma Medical Society Political Action Committee, as guest speakers



Upon his election by acclamation to the office of KMA president-elect, John C. Quertermous, M.D., Murray (left) makes his way to the podium amid a standing ovation and is congratulated by J. S. Oldham, M.D., Owensboro.

at the Seventh Annual KEMPAC Seminar September 22.

The Seminar, attended by 250 physicians and their wives, was held in the Grand Ballroom of the Seelbach Hotel and was presided over by John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board.

Senator Murphy and Senator Bayh presented their views stressing matters that pertained not only to those in the medical profession, but also to private citizens.

Doctor Kenyon stressed the importance of the membership of KEMPAC in getting involved in politics. Noting that there is a record membership in AMPAC this year, Doctor Kenyon urged members to get Kentucky physicians to join KEMPAC.

According to records in the KEMPAC office as of October 15, a record in membership has been set with the total number of KEMPAC members nearing the 1250 mark.



KEMPAC members pose with their guest speakers following the Annual KEMPAC Seminar September 22 at the Seelbach Hotel. Pictured from left to right are U. S. Senator Birch Bayh, D-Ind.; John C. Quertermous, M.D., Murray, chairman of the KEMPAC Board; Henry B. Asman, M.D., Louisville, immediate past president of KMA; Rex Kenyon, M.D., chairman of the Oklahoma Medical Society Political Action Committee; U. S. Senator George Murphy, R-Calif.; (above) C. Kenneth Peters, M.D., Louisville, secretary-treasurer of KEMPAC, and Fred C. Rainey, M.D., Elizabethtown, member of executive committee of KEMPAC Board.



Past, present and future is depicted as John C. Quertermous, M.D., Murray, president-elect; Walter L. Cawood, M.D., Ashland, KMA president, and Henry B. Asman, M.D., Louisville, immediate past president, get together after the final session of the House.

Auxiliary Installs Mrs. Gardner Elects Mrs. Hornaday

Mrs. Hoyt D. Gardner, Louisville, was installed as president of the Woman's Auxiliary of the Kentucky Medical Association during its Annual Convention September 22-24 in Louisville. Mrs. Charles E. Hornaday, Owensboro, was chosen as president-elect. Mrs. Gardner succeeds Mrs. William H. McBeath, Lexington, who presided at the meeting.

Other officers elected during the meeting were Mrs. Orville Stein, Somerset, first vice president; Mrs. Edwin T. Davis, Paducah, second vice president; Mrs. Joseph Wheeler, Ashland, third vice president; Mrs. James Ferrell, Paris, fourth vice president; Mrs. James Gulley, Madisonville, recording secretary, and Mrs. James T. Linville, Louisville, corresponding secretary.

Re-elected to office were Mrs. Bernard Schoo, Louisville, treasurer, and Mrs. J. Murray Kinsman, Louisville, parliamentarian.

This year's luncheon was highlighted with a travel and packing tips program presented by American Airlines and a "fun" survey done among the Auxiliary to determine what was characteristic of the ideal M.D.'s wife.

Mrs. R.L.C. Robertson, president-elect of the Woman's Auxiliary to the American Medical Association, was the guest speaker for the Auxiliary luncheon. The Junior League of Lexington was presented the Community Service Award for their work in creating a sheltered workshop for the mentally retarded.

Former KMA President Named As Blue Plans Director

J. Duffy Hancock, M.D., has been appointed medical director for the Blue Plans, according to J. Ed McConnell, president, Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc.

Doctor Hancock replaces Stanley T. Simmons, M.D., who retired from this position October 1.

A former KMA president from 1953 to 1954, Doctor Hancock is one of the original members of the Board of Kentucky Blue Shield and served as its president from 1957 to 1958.

Blue Shield Elects New Directors

Following the KMA Annual Meeting, four new physicians were elected to full terms on the Kentucky Physicians Mutual, Inc. Board of Directors. Elected were: Henry B. Asman, M.D., Louisville; Peter Bosomworth, M.D., Lexington; Hoyt D. Gardner, M.D., Louisville, and Richard Grise, M.D., Bowling Green.

Luncheon Speaker Remarks On Current Political Thought

"An exercise in definition is what I'm giving you today," M. Stanton Evans told more than 300 physicians, their wives and guests at the President's Luncheon September 24 during the Annual Meeting.

In doing so, Mr. Evans explored the cliches and catchwords so prominent in current political and economic discussions. Progress, for example, he said, is a loaded term, its meaning having changed drastically since the days of our founding fathers.

Touching on some of the political and economic issues which confront the country, Mr. Evans told the audience what the future holds "for those of us who cherish the institutions of a free society."

The Indianapolis editor noted that we are in an "axial" period in politics—the principles of the American system, those of our founding fathers, the constitution, etc., are now at one with political thought.



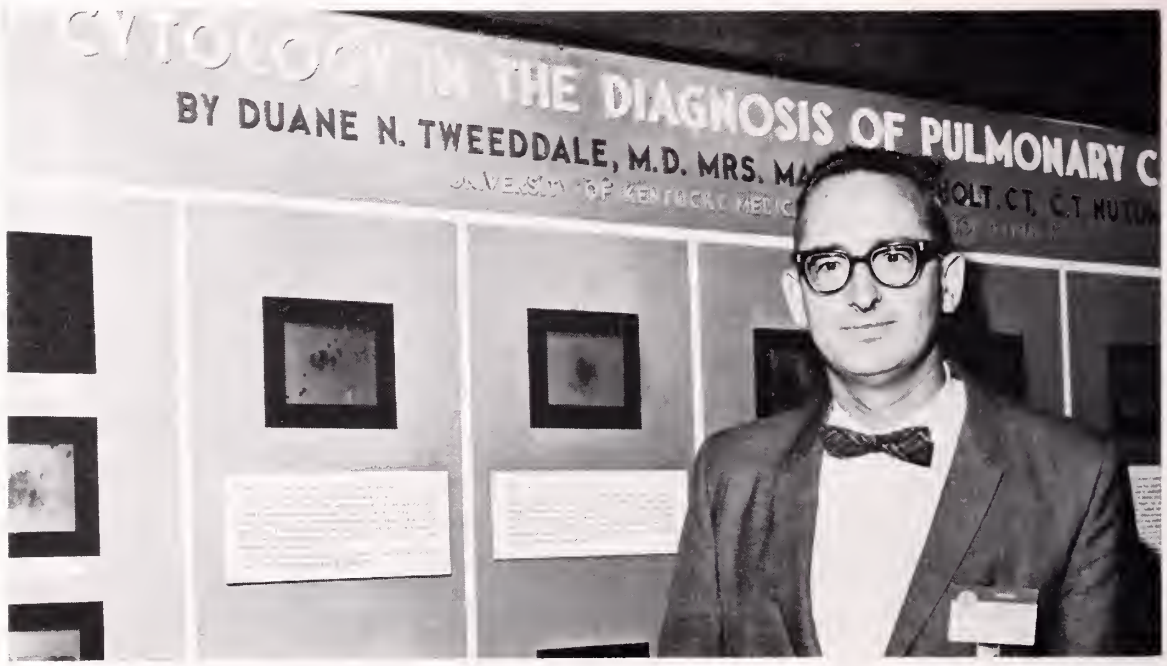
M. Stanton Evans, editor of the Indianapolis News, addresses physicians and their wives at the President's Luncheon. Mr. Evans talk was entitled "The Future of Freedom."



The six reference committees who studied and made recommendations to the House on 49 reports and 12 resolutions were led by these chairmen: (left to right) John M. Baird, M.D., Danville; Donn L. Smith, M.D., Louisville; N. L. Bosworth, M.D., Lexington; James B. Cox, M.D., Hopkinsville; Paul J. Parks, M.D., Bowling Green, and Edward N. Maxwell, M.D., Louisville.



Participants in the Crackerbarrel Session divided into 20 informal groups to discuss timely medical topics. The Crackerbarrel Session, held September 24, was well attended by physicians and proved to be an enlightening part of the scientific program.



The scientific exhibit, honored as 1st-Place at the Annual Meeting, was the Lung Cancer Screening Booth presented by Duane Tweeddale, M.D. (above), C.T. Nuzum, M.D., and M.L. Holt, CT (ASCP). Sputum collections were taken and scanned for the presence of atypical cells, with results forwarded to those physicians who were tested.



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Agroun

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] ck a large rock tially capsized. The fire depar had to rescue Waters by smal Damage to the yacht is estima

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



73 Physicians Attend Ninth KMA Orientation Program

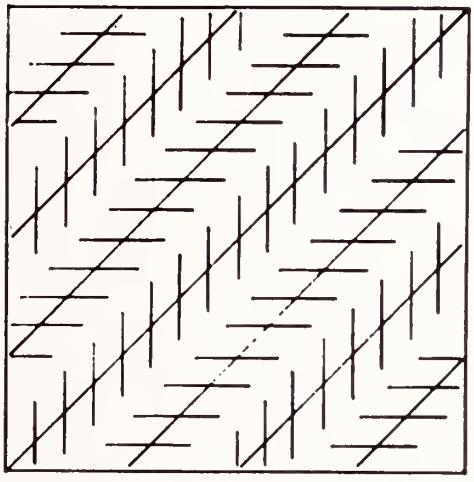
Seventy-three physicians attended the Ninth Orientation Program for new KMA members on September 22, according to N. Lewis Bosworth, M.D., Lexington, chairman of the Committee on Communication and Health Education.

The Orientation Program, held two times a year, during the Annual and Interim Meetings, is designed to better equip new KMA members in meeting present-day responsibilities as a citizen and as a physician.

Listed below are the names of those physicians who attended the September 22 session. If you were present and your name is not listed please notify the KMA Headquarters Office.

Brown L. Adkins, M.D., Sandy Hook
Leonard S. Berman, M.D., Maysville
J. Bradford Block, M.D., Louisville
Robert B. Boettner, M.D., Lexington
Lloyd M. Browning, M.D., Louisa
Edward Callahan, M.D., Louisville
Glenn Cardenas, M.D., Maysville
W. Neville Caudill, M.D., Louisville
Alfred L. Chatham, M.D., Louisville
Ronald G. Chism, M.D., Louisville
Robert C. C. Chiu, M.D., Louisville
Lee R. Chutkow, M.D., Louisville
David V. Cole, M.D., Campbellsville
Chester L. Davidson, M.D., Louisville
Loretta T. Davis, M.D., Louisville
Cyrus M. Day, M.D., Louisville
Mariano M. Diaz, M.D., Falmouth
Charles E. Dobbs, M.D., Louisville
John A. Dooling, M.D., Lexington
Norman E. Edwards, M.D., Louisa
David E. Eifrig, M.D., Lexington
Robert B. Elliott, M.D., Millersburg
O. Tom Evans, M.D., Henderson
George J. Gataky, Jr., M.D., Louisville
Harold R. Gillespie, M.D., Whitesburg
Ronald D. Hamilton, M.D., Lexington
Jack L. Hamman, M.D., Madisonville
James W. Harkess, M.D., Louisville
Arthur A. Hellebusch, M.D., Lexington
Franklin Hoffman, M.D., Louisville
Frank M. Jenkins, Jr., M.D., Lexington
Mark A. Judge, M.D., Central City
Hebry B. Keister, M.D., Mayfield
Prue W. Kelly, M.D., Murray
Carlos A. Leguizamon, M.D., Louisville
Thomas P. Leonard, Jr., M.D., Shelbyville
Rondall Hall Leslie, M.D., Salyersville
Carolyn R. McKelvey, M.D., Louisville
Jules J. McNerney, M.D., Hopkinsville
Victor J. Magary, M.D., Covington
John J. Martin, Jr., M.D., Louisville
Joan K. Mattingly, M.D., Lexington
Fred T. Moore, M.D., Louisville
Phatick K. Mukherji, M.D., Louisville
Robert L. Nold, M.D., Louisville
Earnest F. Oblander, M.D., Louisville
Mary L. Osborne, M.D., Louisville
Dogoberto Jose Perez, M.D., Louisville
R. Herman Playforth, M.D., Lexington
David F. Preston, M.D., Lexington
Larry A. Raymond, M.D., Louisville
Glen D. Richards, M.D., Lewisport
A. Eddie Romero, M.D., Louisville
Remigio T. Roque, M.D., Lynch
James E. Russell, M.D., Lexington
Myron G. Sandifer, Jr., M.D., Lexington
Theodore Steffen, M.D., Louisville
David Steinman, M.D., Harlan
Charles O. Stephens, M.D., Ft. Mitchell
Robert L. Strawn, M.D., Covington
Jerry C. Sutkamp, M.D., Bellevue
Wilmier Talbert, M.D., Lexington
Vincent R. Taormina, M.D., Lexington
Sam H. Traughber, M.D., Hopkinsville
Roy J. Vermillion, M.D., Franklin
Ron Waldridge, M.D., Shelbyville
James D. Walker, M.D., Louisville
Wilbur H. Wilson, M.D., Cynthiana
Donald W. Wright, M.D., Louisville
Charles R. Wolf, M.D., Lexington
John W. Yarbro, M.D., Lexington
Tatsuo Yoneyama, M.D., Lexington
Stephen J. Zwirek, M.D., Lexington

OPTICAL ILLUSION?



All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.

Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

Faculty Awards Presented To Drs. Bosomworth, Fishel

The 1969 recipients of the KMA Faculty Scientific Achievement Awards were Peter P. Bosomworth, M.D., Lexington, and Charles Fishel, Ph.D., Louisville. The awards, presented at the President's Luncheon September 24, are given each year to a faculty member of each of the two medical schools in the state.

The KMA Committee on Medical Education established the award in 1962 to be presented annually to one who has done outstanding research or made considerable contribution to the field of medicine.

Doctor Bosomworth, associate dean for clinical affairs of the University of Kentucky College of Medicine, came to the Medical Center as chairman of the then new department of anesthesiology in 1962. Under his leadership and direction, the department has come to be known as one of the most outstanding departments of anesthesiology in the country. Doctor Bosomworth has contributed to the medical profession in research, his work in clinical anesthesiology and teaching.

Doctor Fishel, as chairman of the department of microbiology at the University of Louisville School of Medicine since 1964, has worked to reorganize this department with a thorough teaching and research program now established. His work in microbiology has achieved significant recognition under a nationally recognized research effort within the department.

Two Physicians, One Layman Receive KMA's Top Awards

Branham B. Baughman, M.D., Frankfort; James M. Stevenson, M.D., Brooksville, and Mr. Charles F. Hancock, Louisville, are recipients of the three top awards presented by the Kentucky Medical Association. Award presentations were made September 24 at the President's Luncheon, by Richard F. Grise, M.D., Bowling Green, Awards Committee chairman.

The Distinguished Service Award, presented annually to the physician selected as the most outstanding member of the Kentucky Medical Association, went to Doctor Baughman.

Doctor Stevenson, who has practiced medicine 50 years in Bracken County, received the Outstanding General Practitioner Award for the significant contributions he has made to the medical profession and his community.

The R. Haynes Barr Award, which is designed to honor a lay person for outstanding accomplishment in the field of public health and/or medical care, was presented to Mr. Hancock for his work with narcotic addicts.

A member of the Council from 1950 to 1958 and its former chairman 1954-55, Doctor Baughman has contributed much to organized medicine. He is past president and presently treasurer of Blue Shield and is also a former president of the Franklin County Medical Society. Doctor Baughman has done much for community health betterment as president of the Kentucky Board of Health from 1960 to 1968.



KMA Award winners are congratulated by Richard F. Grise, M.D., Bowling Green, at the President's Luncheon September 24. Branham B. Baughman, M.D., (left) Frankfort, received the Distinguished Service Award; Mr. Charles F. Hancock, the R. Haynes Barr Award, and James M. Stevenson, M.D., (right) Brooksville, the Outstanding General Practitioner Award.

A 1917 graduate of the University of Louisville, Doctor Stevenson was a Board of Trustees member from 1943 to 1961 and served as its chairman from 1960 to 1961. A recipient of numerous honors and awards, including a Presidential citation in 1945 for his work with the USO, he was selected as one of the outstanding leaders in America in 1967.

Known for his effective service on the Narcotics Control Division of the Department of Health during the past 20 years, Mr. Hancock has long been active in medical affairs, serving as the first director of the Kentucky Heart Association and working as the Medical Practice Investigator for the State Health Department in 1949. Mr. Hancock's policy in dealing with narcotic addicts is one of treatment and rehabilitation in preference to punishment for such offenses.

Florida Medical Deanship Goes To Ex-U.L. Dean, Dr. Smith

Donn L. Smith, M.D., Louisville, has been named dean of a new medical school to be built at the University of South Florida in Tampa.

Doctor Smith, who was dean of the University of Louisville School of Medicine until last July 1, will also be director of the Tampa school's medical center which includes a community hospital, a 725-bed Veterans Hospital under construction and a state mental hospital that will be started next year.

Active in KMA activities, Doctor Smith served on the KMA Medical Education Committee, the Educational Television Committee, the Advisory Committee to Selective Service, and the Committee on Plans and Development.

KMA Again Attains Record Membership For 1969

Membership figures are up again for KMA physicians, according to the records of the membership department as of October 15. The total number of active Kentucky physicians who are members of KMA is 2375, which is 128 more than this time last year.

One hundred per cent KMA and AMA membership has declined somewhat from last year. This year 66 counties have 100% KMA membership and 39 counties have 100% AMA membership, as compared to 68 and 45 counties respectively for 1968.

The chart below contains membership figures for each county as supplied by the membership department. Figures do not include associate and emeritus members.

Number of Active Physicians in Kentucky Counties Who Are Members of KMA and AMA October 15, 1969

COUNTIES	Active Physicians	MEMBERS KMA	MEMBERS AMA
Adair	7	6	6
Allen	6	5	5
Anderson (*)	3	3	1
Ballard (*) (**)	3	3	3
Barren	24	23	20
Bath	3	2	1
Bell	28	27	26
Boone (*) (**)	16	16	16
Bourbon	14	13	3
Boyd	54	51	51
Boyle	23	18	12
Bracken	3	2	1
Breathitt (*) (**)	3	3	3
Breckinridge (*) (**)	6	6	6
Bullitt (*) (**)	5	5	5
Butler (*) (**)	2	2	2
Caldwell	6	5	5
Calloway	18	17	17
Campbell-Kenton	160	152	122
Carlisle (*) (**)	2	2	2
Carroll (*)	5	5	4
Carter (*)	2	2	1
Casey (*) (**)	5	5	5
Christian	41	37	37
Clark	14	12	11
Clay (*) (**)	5	5	5
Clinton (*) (**)	2	2	2
Crittenden (*) (**)	1	1	1
Cumberland	2	1	1
Daviess	66	62	57
Edmonson (*) (**)	2	2	2
Elliott (*)	2	2	1
Estill (*) (**)	3	3	3
Fayette	386	330	294
Fleming (*)	4	4	1
Floyd	21	10	9
Franklin	36	34	27
Fulton (*) (**)	8	8	8
Gallatin (*) (**)	1	1	1
Garrard (*) (**)	3	3	3
Grant (*) (**)	4	4	4
Graves	16	15	15
Grayson	6	4	4
Green (*)	7	7	6
Greenup (*) (**)	7	7	7
Hancock (*)	3	3	0
Hardin	27	26	19
Harlan	42	37	37
Harrison (*)	8	8	4
Hart	6	4	4
Henderson	31	28	28
Henry (*) (**)	3	3	3
Hickman (*) (**)	2	2	2
Hopkins	49	45	43
Jackson (*) (**)	1	1	1
Jefferson	826	793	628
Jessamine	7	6	3
Johnson (*) (**)	11	11	11
Kenton—See Campbell			
Knott (*) (**)	2	2	2
Knox	9	8	3
Larue (*)	3	3	1
Laurel (*)	9	9	8
Lawrence	10	9	9
Lee (*) (**)	1	1	1
Leslie	2	0	0
Letcher	14	11	9
Lewis	2	1	0
Lincoln (*) (**)	3	3	3
Livingston	4	2	1
Logan	11	9	8
Lyon (*)	3	3	2
McCracken	66	57	54
McCreary (*) (**)	2	2	2
McLean (*)	3	3	0
Madison (*)	24	24	19
Magoffin (*) (**)	2	2	2
Marion (*) (**)	8	8	8
Marshall (*)	10	10	9
Martin	3	2	2
Mason	14	12	10
Meade (*)	3	3	1
Menifee (*)	2	2	1
Mercer	13	12	11
Metcalfe (*) (**)	1	1	1
Monroe (*) (**)	7	7	7
Montgomery	9	7	6
Morgan (*)	3	3	2
Muhlenberg (*)	12	12	11
Nelson (*) (**)	8	8	8
Nicholas	3	2	2
Ohio	8	7	2
Oldham (*)	8	8	7
Owen (*) (**)	2	2	2
Owsley (*) (**)	2	2	2
Pendleton (*)	4	4	2
Perry (*)	18	18	15
Pike	37	26	24
Powell (*) (**)	1	1	1
Pulaski	28	27	24
Robertson	1	0	0
Rockcastle (*)	2	2	0
Rowan	12	10	10
Russell (*) (**)	3	3	3
Scott (*)	7	7	2
Shelby (*)	8	8	6
Simpson	6	5	4
Spencer (*) (**)	3	3	3
Taylor (*)	7	7	6
Todd (*)	4	4	3
Trigg (*) (**)	6	6	6
Trimble (*) (**)	2	2	2
Union	4	3	3
Warren	50	49	44
Washington (*) (**)	4	4	4
Wayne (*)	6	6	5
Webster	4	3	3
Whitley	19	18	17
Wolfe	2	1	1
Woodford (*)	7	7	2
Totals	2580	2375	2004

* 100% KMA ** 100% AMA

COMPARATIVE REGISTRATION FIGURES

KMA Annual Meetings

	Louisville 1960	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964	Louisville 1965	Louisville 1966	Louisville 1967	Louisville 1968	Louisville 1969
KMA Members	1021	996	1014	865	924	1172	1016	957	1011	1056
Guest Physicians	203	194	208	141	157	138	195	152	153	149
Interns-Residents	105	102	102	69	108	132	121	94	103	95
Medical Students	289	237	176	59	128	193	209	222	185	218
Registered Nurses	25	31	59	31	34	27	33	24	42	27
Exhibitors	239	204	232	212	297	297	312	272	256	305
Guests	99	132	123	132	125	172	126	115	332	339
Technicians— Office Assistants	33	57	71	22	61	55	46	31	29	39
TOTAL ATTENDANCE	2014	1953	1985	1531	1844	2186	2058	1867	2111	2228

Usual and Customary, Utilization, Bylaw Changes Are Considered As KMA House Acts on 49 Reports, 12 Resolutions

The members of the Kentucky Medical Association House of Delegates kept busy during the KMA Annual Meeting, September 22-25, reviewing and taking action on 49 reports and 12 resolutions submitted to them for consideration.

Much activity centered around the "usual and customary" concept and the House reaffirmed that "usual and customary" as adopted by the 1968 session of the House of Delegates constitutes a paid-in-full program with specific requirements recognized (see pages 831-832 for more details).

Resolutions were approved calling for (1) limited licensing of hospital interns to permit them to sign death and birth certificates and to order prescriptions within the hospital, (2) state-wide support for construction of a new Louisville General Hospital, and, (3) urging the Food and Drug Administration to refrain from actions to prohibit the manufacture and sale of useful and reasonably safe combination products.

The establishment and funding of educational programs to meet the requirements of the new Board of Family Practice was approved by resolution and another urged insurers to aggressively extend the provision of ambulatory benefits. County societies were encouraged to take an active part in the formation of the Comprehensive Health Planning Councils in their respective regions.

New committees were created to assist in correcting air and water pollution, to study occupational pulmonary diseases, and to study present and projected KMA financial requirements. The Association reaffirmed its concern in the area of utilization and voted to expand its Claims Review Committee to include review of utilization.

In the field of legislation and governmental medical programs, the Uniform and Anatomical Gift Act and minor consent to V-D therapy were approved for introduction into the state legislature. The Association went on record again favoring legislative changes in Title XIX to initiate token fees by patients for physician and pharmacy services to help curb patient over-utilization. The House reiterated its opposition to any form of national health insurance.

Some changes were made in the KMA Bylaws, one of which would redefine active membership. This change eliminates the requirement for an active member to be a doctor of medicine, and instead states that he must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state. Another Bylaw change authorizes the KMA vice president to become a member of the Executive Committee.

Reports and resolutions submitted to and acted on at the 1969 meeting of the KMA House of Delegates will appear in the December issue of The Journal. It is only possible to touch on some of the highlights in this article.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully intregated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201

now he can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.





No place for beginners

Terramycin®
oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

40160

Was Your Delegate Present?

ROLL CALL—

1969 House of Delegates

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Richard F. Greathouse	Present	Present
Vice-Speaker	Carl Cooper, Jr.		Present
President	Henry B. Asman	Present	Present
President-Elect	Walter L. Cawood	Present	Present
Vice President	Edwin P. Solomon, Jr.		
Secretary	S. Randolph Scheen	Present	Present
Treasurer	Keith P. Smith	Present	
Delegate to AMA	J. Thomas Giannini	Present	Present
Delegate to AMA	Charles C. Rutledge	Present	Present
Delegate to AMA	John C. Quertermous	Present	Present
Alternate Delegate to the AMA	Charles G. Bryant	Present	Present
Alternate Delegate to the AMA	Daryl P. Harvey		Present
Alternate Delegate to the AMA	David B. Stevens	Present	Present

TRUSTEES

District			
First	C. C. Lowry	Present	Present
Second	William W. Hall	Present	Present
Third	Thornton E. Bryan, Jr.	Present	Present
Fourth	W. Bruce Hamilton	Present	Present
Fifth	George A. Sehlinger	Present	Present
Sixth	Rex E. Hayes		Present
Seventh	Donald Chatham	Present	Present
Eighth	Lee C. Hess	Present	Present
Ninth	J. Campbell Cantrill	Present	Present
Tenth	Andrew M. Moore	Present	Present
Elevenrh	Douglas H. Jenkins	Present	Present
Twelfth	Robert N. McLeod, Jr.	Present	Present
Thirteenth	Paul E. Holbrook		
Fourteenth	Ballard W. Cassady	Present	Present
Fifteenth	E. C. Seeley	Present	Present

PAST PRESIDENTS

Past President	George F. Brockman	Present	Present
Past President	Robert E. Pennington	Present	Present
Past President	Everett H. Baker	Deceased	
Past President	Delmas Clardy		Present
Past President	George Archer	Present	Present

DELEGATES

First District

County		First Session	Second Session
BALLARD	Glenn D. Baird		
CALLOWAY	Hugh Houston		
	Conrad Jones (Alt.)	Present	
CARLISLE	J. T. O'Neill		
FULTON	Glynn F. Bushart		
GRAVES	Henry B. Keister	Present	Present
HICKMAN	C. J. Mills		
LIVINGSTON			
McCRACKEN	W. Burton Haley	Present	Present
	Walter Johnson	Present	Present
	W. Eugene Sloan		
	C. M. Blanton (Alt.)	Present	Present
MARSHALL	Keith Ellis	Present	Present

Second District

DAVIESS	Coy Ball	Present	Present
	J. S. Oldham	Present	Present
	Joseph C. Stiles	Present	Present
HANCOCK	Glen D. Richards	Present	Present
HENDERSON	Kenneth Eblen	Present	Present
	Charles Kissinger	Present	
McLEAN	Everett S. Coleman	Present	Present
OHIO			
UNION	Wallas Bell	Present	Present
WEBSTER			

Third District

CALDWELL			
CHRISTIAN	W. Faxon Payne		Present
	James B. Cox	Present	Present
CRITTENDEN	R. M. Brandon		
HOPKINS	Faull Trover	Present	Present
	Loman C. Trover		
	Charles R. Fisher (Alt.)	Present	Present
LYON	Robert H. Hyde		
MUHLENBERG	Mark A. Judge	Present	Present
TODD	Ralph D. Lynn	Present	Present
TRIGG	Thornton E. Bryan, Jr.	Present	Present

Fourth District

BRECKINRIDGE	James G. Sills	Present	
BULLITT	Patrick Murphy	Present	Present
GRAYSON	P. A. O'Neill		
	Ray A. Cave (Alt.)	Present	
	Ralph A. Thomas		Present
GREEN	Robert Simmons	Present	Present
HARDIN	Clyde Brassfield	Present	Present
	Fred Rainey	Present	Present
HART	Keene M. Hill, Jr.	Present	Present
LARUE	Marion A. Douglass, Jr.	Present	Present
MARION			
MEADE			
NELSON	Kenneth L. Stinnette	Present	Present
TAYLOR	H. F. Chambers	Present	Present
WASHINGTON	Richard A. Hamilton	Present	Present

Fifth District

JEFFERSON	John D. Allen, Jr.	Present	Present
	James G. Baker	Present	Present
	William H. Bizot	Present	Present
	Thomas E. Booth	Present	Present
	Glenn W. Bryant	Present	Present
	Peter C. Campbell, Jr.		Present
	Elbert G. Christian	Present	
	Fred E. Coy, Jr.	Present	Present
	Morgan R. Colbert	Present	
	John H. Doyle		Present
	Harold G. Eskind		Present
	Frank M. Gaines, Jr.	Present	Present
	R. F. Greathouse	Present	Present
	Cecil Grumbles		Present
	Harold W. Haller, Sr.	Present	Present
	N. I. Handelman	Present	Present
	Walter I. Hume, Jr. (Alt.)		Present
	Stuart M. Hunter		Present
	John S. Llewellyn (Alt.)		Present
	Roy A. Martin	Present	Present
	Edward Maxwell	Present	Present
	Robert L. McClendon	Present	Present
	Clyde T. Moore	Present	Present
	Herman R. Moore, Jr.	Present	Present
	Charles R. Oberst	Present	Present
	F. Albert Olash		Present
	Bernard I. Popham	Present	Present
	Carroll H. Robie	Present	Present
	W. Fielding Rubel	Present	Present
	F. B. Schoenbachler	Present	Present
	Charles C. Smith, Jr.		Present
	Donn L. Smith	Present	Present
	Robert C. Tate	Present	Present
	Robert S. Tillett		Present

Sixth District

ADAIR	Oris Aaron		
ALLEN	Earl P. Oliver	Present	Present
BARREN	William H. Bryant	Present	
	E. L. Marion (Alt.)		Present
BUTLER	D. G. Miller, Jr.		
CUMBERLAND	Joseph Schickel		Present
EDMONSON	S. E. Farmer		
LOGAN	C. V. Dodson	Present	
METCALFE	L. P. Emberton		
MONROE	J. Jack Martin	Present	
SIMPSON	Douglas R. Alvey		
WARREN	Paul J. Parks	Present	Present
	J. O. Willoughby	Present	Present

Seventh District

ANDERSON	Boyd Caudill		
CARROLL	Edgar S. Weaver		
FRANKLIN	B. B. Baughman	Present	Present
	Sandford Weiler		
	Harold Johnson (Alt.)	Present	Present
GALLATIN	John D. Fielding, Jr.	Present	
GRANT	Darl B. Shipp		
HENRY	Robert Houston	Present	Present

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 22 and 24.

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

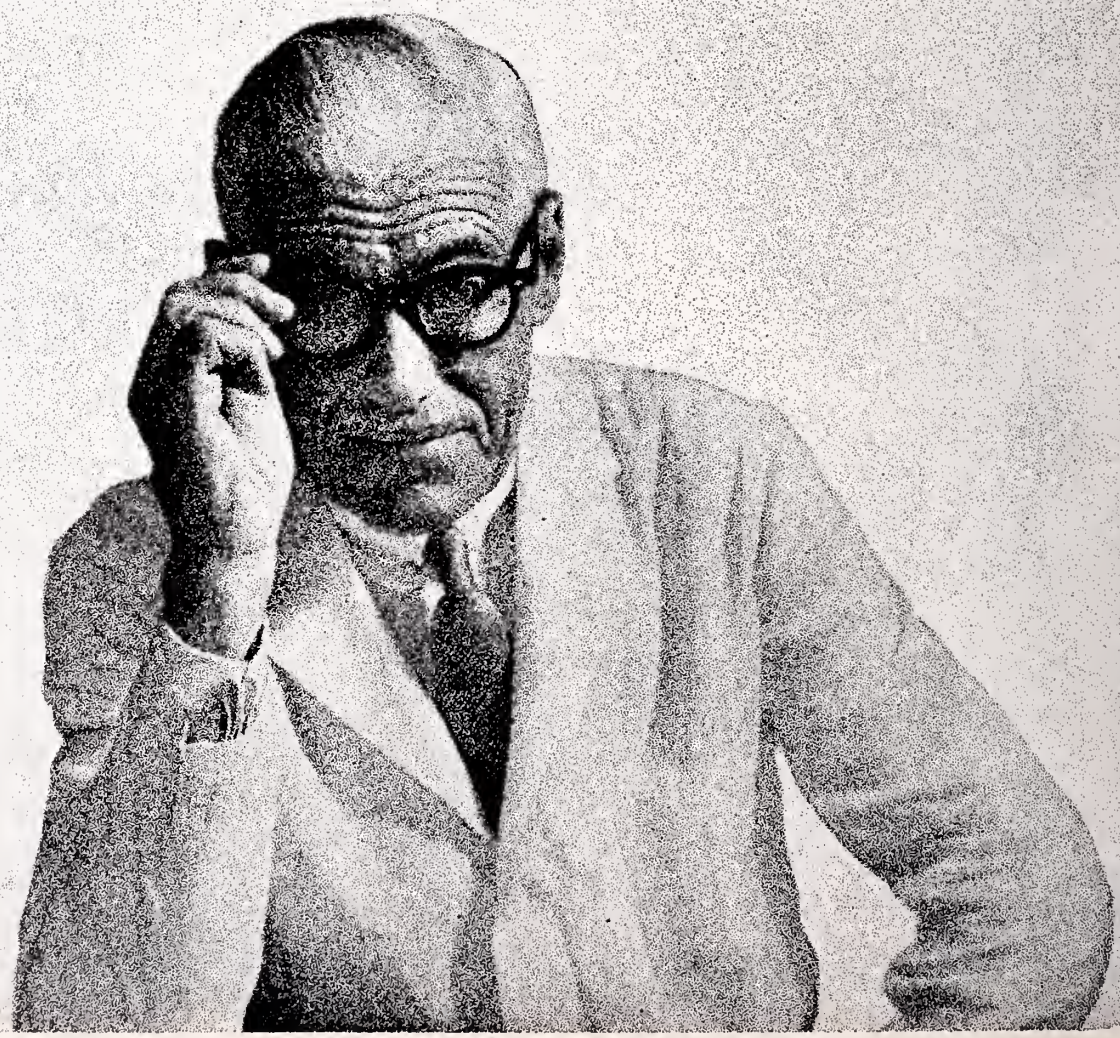
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society



OLDHAM	Burl Mack		Present
OWEN	Oscar A. Cull		
SHELBY	M. D. Klein		
	T. P. Leonard, Jr. (Alt.)		Present
SPENCER	M. H. Skaggs		
TRIMBLE	Carl Cooper, Jr.		Present

Eighth District

BOONE	Glenn F. Baird	Present	Present
CAMPBELL-KENTON	John C. Gunn	Present	
	Thomas L. Heavern, Jr.	Present	Present
	Donald Janney	Present	Present
	Paul Klingenberg		Present
	Richard Menke		Present
	Louis J. Nutini	Present	
	W. Vinson Pierce	Present	Present

Ninth District

BATH			
BOURBON	Richard Wever	Present	Present
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	Samuel W. Gehring		
	Robert W. Fidler (Alt.)	Present	
HARRISON	Wilbur H. Wilson		
	Henry Moody (Alt.)	Present	
MASON	William Savage	Present	
	Mitchel Denham (Alt.)		Present
NICHOLAS	W. R. Kingsolver		
PENDLETON	William M. Townsend		
SCOTT	R. Kendall Brown	Present	Present
ROBERTSON			

Tenth District

FAYETTE	John F. Berry, Jr.	Present	Present
	Leslie W. Blakey	Present	Present
	M. Cary Blaydes	Present	Present
	Peter P. Bosomworth	Present	
	N. L. Bosworth	Present	Present
	Thomson R. Bryant, Jr.	Present	Present
	Winston L. Burke	Present	Present
	Donald E. Edger (Alt.)		Present
	Richard D. Floyd	Present	Present
	Richard F. Hench	Present	Present
	David A. Hull	Present	Present
	Bush A. Hunter	Present	Present
	Richard B. McElvein	Present	Present
	Carl H. Scott	Present	Present
	Ben C. Stigall	Present	Present
JESSAMINE	J. Sankey Williams	Present	Present
WOODFORD	Francis D. Willey	Present	

Eleventh District

CLARK			
ESTILL	Charles E. Terry		
JACKSON	D. L. Peterson		
LEE			
MADISON	Tom Epling	Present	Present
	Hugh Mahaffey		
	Maxwell C. Kimball (Alt.)	Present	Present
MENIFEE	Donald L. Graves		
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	M. B. Gabbard		Present
POWELL			
WOLFE			

Twelfth District

BOYLE	John M. Baird	Present	Present
CASEY	Lewis E. Wesley		
	G. W. Sweeney (Alt.)		Present
CLINTON	Earnest A. Barnes		
GARRARD	O. S. Playforth	Present	Present
LINCOLN	Giles L. Stephens		
McCREARY	H. A. Perry		
MERCER	Frank Whalen		
PULASKI	John P. Hill	Present	
	Stephen B. Kelley	Present	Present
ROCKCASTLE			
RUSSELL	James E. Monin		
WAYNE	John W. Simmons		Present

Thirteenth District

BOYD	John Harrison	Present	
	Clyde C. Sparks	Present	Present
	Max Wheeler		Present
	Guy Cunningham (Alt.)		Present
CARTER			
ELLIOTT	Brown L. Adkins		
GREENUP			
LAWRENCE	William J. McNabb		Present
LEWIS	Elwood Esham		
MORGAN	Alec Spencer		
ROWAN			

Fourteenth District

BREATHITT	F. C. Lewis		
FLOYD	Lowell Martin	Present	Present
JOHNSON	Glenn R. Powell		
KNOTT	Gene T. Watts		Present
LETCHER	Jim B. Tolliver	Present	Present
MAGOFFIN			
MARTIN	Raymond D. Wells	Present	Present
PERRY	Keith Cameron		Present
PIKE	Max P. Jones	Present	Present
	Harvey A. Page		

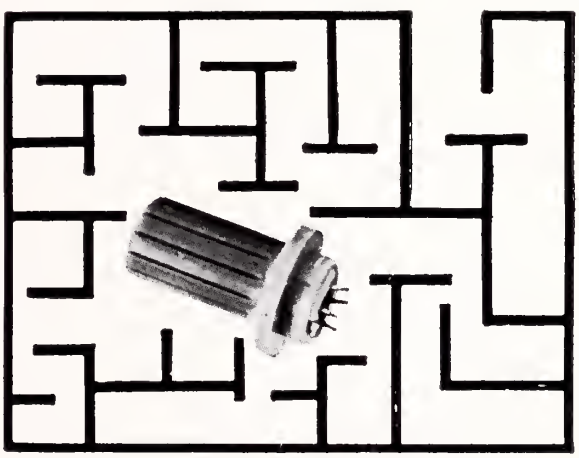
Fifteenth District

BELL	Charles B. Stacy	Present	
	Kenneth W. Smith	Present	Present
CLAY	W. L. Becknell		
	J. L. Becknell (Alt.)	Present	
HARLAN	Henry C. Evans	Present	Present
	R. Smith Howard	Present	
KNOX	Harold L. Bushey	Present	Present
LAUREL	John B. Rypstra	Present	Present
LESLIE	Mary Pauline Fox		
WHITLEY	Roemer D. Pitman	Present	

4th Cancer Symposium Is Nov. 28

The fourth Cancer Symposium, sponsored by the department of surgery, postgraduate medical education of St. Joseph Infirmary and the Kentucky Division, American Cancer Society, will be held November 28 in Lourdes Hall, St. Joseph Infirmary at 8 a.m.

Alex Haller, M.D., professor of pediatric surgery, Johns Hopkins University School of Medicine, will be the guest lecturer for the symposium.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

473-9

Canadian Surgeon Will Deliver 17th Yandell Lecture Nov. 24

Angus Duncan McLachlin, M.D., professor and chairman of the department of surgery at the University of Western Ontario, will deliver the 17th annual David W. Yandell Lecture Monday, November 24.

The lecture, which is being held at 11 a.m. in the Rankin Amphitheater of Louisville General Hospital, is sponsored by the Louisville Surgical Society and the University of Louisville School of Medicine.

Doctor McLachlin is a Fellow of the Royal College of Surgeons, both Canadian and English, and a Fellow of the American College of Surgeons. His topic for the lecture is "Venous Thrombosis and its Sequelae." Doctor McLachlin, who has published extensively in the field of physiological research and in clinical surgery, will take part in the annual Louisville Surgical Society dinner and participate in conferences and seminars at the School of Medicine.

The Yandell Lectureship is held each year in honor of the late David W. Yandell, M.D., the founder of the Louisville Surgical Society and past-president of the American Medical Association.

Conference Name Changes

The Chicago Medical Society has changed the name of its clinical conference to the Midwest Clinical Conference of the Chicago Medical Society. The next meeting of the conference will be at The Sherman House, Chicago, March 1-4, 1970.

Ec-
on-
omy!

Dicarbosil®
ANTACID

Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.



ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Annual Meeting Receives Praises From Guests and Speakers

"I was certainly impressed with the fashion in which the meetings were organized and conducted. I hope I contributed in some measure to their success."

M. E. Lahey, M.D.
Department of OB-GYN
University of Utah
Salt Lake City, Utah

"Please express my thanks to the officers of the Association for inviting me to the meeting which I found to be a valuable experience."

Jack C. Geer, M.D.
Department of Pathology
Ohio State University
Columbus, Ohio

"Let me express my appreciation for all the courtesies extended to me at the meeting of the Association. It was a pleasure to meet with your group, and the program was certainly diversified and well planned. I enjoyed the opportunity of visiting with many old friends in Kentucky."

Warren H. Pearse, M.D.
Department of OB-GYN
University of Nebraska
Omaha, Nebraska

"It was indeed a pleasure to attend your interesting meetings and I want to thank you for your kind hospitality extended to me during my stay. It is always a pleasure to meet other individuals involved in the medico-political arena and to observe the operation of events in sister states."

Lowell H. Steen, M.D.
President-Elect
Indiana State Medical Association
Indianapolis, Indiana

"I want to express my appreciation to you and your staff for your courtesies and hospitality extended to me during the recent meeting of the Kentucky Medical Association."

John C. Duffy, M.D.
Medical Director
International Business Machines Corp.
New York, New York

"I greatly enjoyed taking part in the panel and Crackerbarrel discussion of the KMA, and I would like also to thank you personally for the very effective arrangements which were made throughout the meeting."

Marvin D. Siperstein, M.D., Ph.D.
Professor of Internal Medicine
University of Texas
Dallas, Texas

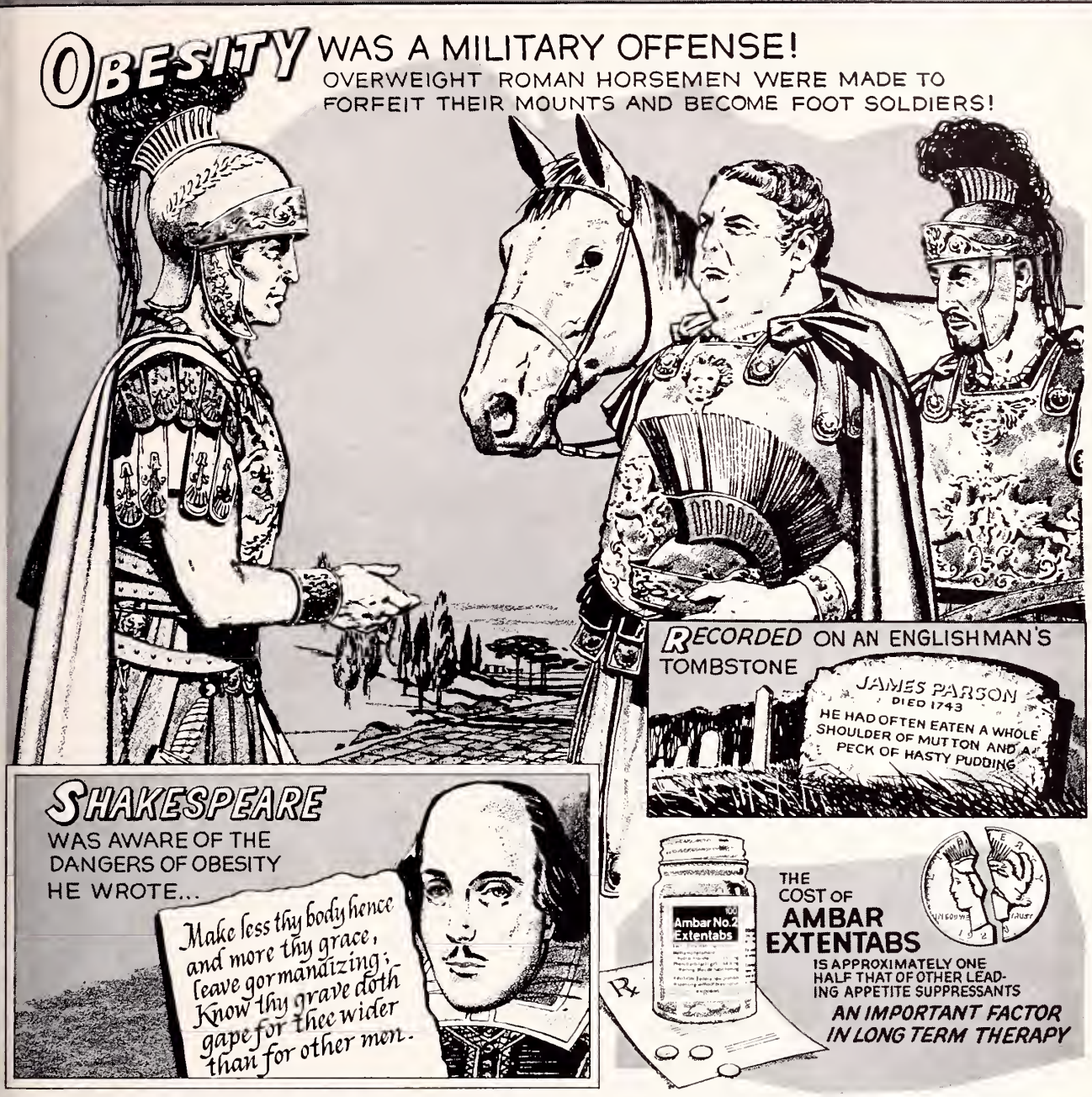
"I wish to thank you for the great Kentucky hospitality you shared with me at your convention. Going to Kentucky could easily become a habit."

Carl E. Clark, M.D.
First Vice President
Illinois State Medical Society
Chicago, Illinois

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind.

BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 30, 1969
2. Title of Publication: THE JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION.
3. Frequency of issue: Monthly
4. Location of known office of publication: 3532 Janet Avenue, Louisville, Jefferson County, Kentucky 40205.
5. Location of the headquarters or general business offices of the publishers: Same as above.
6. Names and address of Publishers, Editor, and Managing Editor: Publisher—Kentucky Medical Association, 3532 Janet Avenue, Louisville, Ky. 40205. Editor—Walter S. Coe, M.D., 568 Medical Towers South, Louisville, Ky. 40202. Managing Editor—Robert G. Cox, 3532 Janet Avenue, Louisville, Ky. 40205.
7. Owner: Kentucky Medical Association.
8. Known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages or other securities: None.
9. Nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual): The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

	Average No. Copies each issue during preceding 12 months	Single issue nearest filing date
A. Total No. Copies printed:	3117	3100
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales:	107	129
2. Mail Subscriptions:	2629	2670
C. Total paid circulation:	2736	2799
D. Free distribution including samples by mail, carrier, or other means:	317	272
E. Total distribution:	3053	3071
F. Office use, left-over, unaccounted, spoiled after printing:	64	29
G. Total:	3117	3100

I certify that the statements made by me above are correct and complete.

Robert G. Cox, Managing Editor

F.A.C.S. Degree Awarded To 12 Kentucky Surgeons

Twelve Kentucky physicians were recently inducted as Fellows of the American College of Surgeons at the organization's 55th Annual Clinical Congress in San Francisco, October 6-10.

The degree is awarded to those physicians who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one or another of the branches of surgery.

Those receiving this distinction from Kentucky are Robert E. Arnold, M.D., Louisville; Andrievs J. Dzenitis, M.D., Louisville; Stuart E. Harlowe, M.D., Louisville; J. Wesley Johnson, M.D., Ashland; Donal J. Kaderabek, M.D., Elizabethtown; Wayne C. Liles, M.D., Henderson; Henry N. Meiers, Jr., M.D., Bowling Green.

Others receiving the F.A.C.S. degree were Olney M. Patrick, M.D., Frankfort; Edward H. Ray, Jr., M.D., Lexington; Nelson B. Rue, Jr., M.D., Bowling Green; John J. Ryan, Jr., M.D., Louisville; and R. John Sanders, M.D., Owensboro.

LEASING
TAILORED FOR
Doctors!

The quickest, easiest, most economical way to acquire a car.

Conserve your precious time and keep your cash!

Let us do your
Car shopping for you!
(Any make or model)

WE ALSO LEASE
Medical & Surgical Equipment and Office Furnishings

Why Make a Capital Investment?

General LEASING
CORPORATION
A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE
Louisville—St. Matthews
897-1641 **895-2451**

April 8-9 Are New Dates For 1970 KMA Interim Meeting

The 1970 KMA Interim Meeting will be held April 8-9 at Kentucky Dam Village State Park, Gilbertsville, rather than on April 15-16 at Lake Barkley Lodge as previously announced. KMA members are urged to change these dates on their calendars.

A delay in construction on Lake Barkley Lodge was the reason for the change in location and dates of the session. The KMA Interim Meeting Program Committee is meeting at Kentucky Dam Village this month to finalize plans for the April 8-9 session.

As is customary, an Orientation Program for new members and a meeting of the Woman's Auxiliary to KMA will be held during the Interim Meeting.



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

Robitussin-DM Cough Calmers

A·H·ROBINS

Cardiac Pacemakers

(Continued from Page 824)

the temporary circuit and from the failing unit arises if interruption of pacing by the latter is not accomplished. In order to avoid such complications, it is suggested that the surest means of stopping myocardial stimulation by the failing pacemaker is by its immediate removal following insertion of a temporary pacing electrode pervenously.

References

1. Zoll, Paul M.: Resuscitation of the heart in ventricular standstill by external electrical stimulation. *New England J. Med. 247*: 768, 1952.
2. Furman, Seymour: Cardiac pacing. *American Heart J. 70*: 830-33, 1965.
3. Humphries, J. O'Neal. Treatment of heart block with artificial pacemakers. *Modern Concept of Cardiovascular Disease, Vol.* XXXIII, No. 6, June, 1964.
4. Tavel, Morton E., Fisch, Charles: Repetitive ventricular arrhythmia resulting from artificial internal pacemaker. *Circulation Vol.* 30: 493-500, October, 1964.
5. Ottinger *et al*: Ventricular fibrillation induced by an implanted cardiac pacemaker. *New England J. Med.*, Vol. 273, 1426, 1965.

Insurance Page

(Continued from Page 815)

mitted with the report. It has been the writer's practice to accept checks which accompanied the original request for information and to submit a bill to the company showing a credit in the amount that was accepted, and that a balance was due.

It is the writer's opinion that if this practice were followed by all doctors, the insurance companies would soon become aware that it is necessary for them to pay a reasonable fee to obtain information about a patient and that it would be to their benefit to authorize a full examination on all patients applying for insurance.

Those of you who disagree with this view are encouraged to write letters to the Insurance Editor of the Kentucky Medical Journal.

LEWIS DICKINSON, M.D.

Owensboro Dr. Heads Orthopods

Joseph Stiles, M.D., Owensboro, was elected president of the Kentucky Orthopaedic Society. The Society, which met during the Annual Meeting, also elected John Ashworth, M.D., Ashland, as vice president, and John McKay, M.D., Owensboro, as secretary-treasurer.

Ky. Health Department Issues Memo On Narcotic Law

The KMA office recently received a copy of a memorandum sent to all pharmacists which stated that it had been brought to the attention of the Kentucky Department of Health that some pharmacists are filling narcotic prescriptions written by physicians for office or bag use.

The memo noted that this is a violation of the narcotic law. "Physicians must order narcotic drugs for bag or office use on Official Narcotic Order Forms and the order form must be filled by a wholesaler or manufacturer," according to Martin Niswonger, director of the Office of Narcotic and Drug Control.

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

Mark Your Calendar

1970 KMA Interim Meeting

April 8-9

Kentucky Dam Village State Park

Gilbertsville, Ky.

First Family Practice Exam Set

The American Board of Family Practice announces that it will give its first examination for certification in various centers throughout the United States. The exam will be over a two-day period on February 28-March 1, 1970.

Information regarding the exam and eligibility for it can be obtained from Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

New Officers For OB-GYN Society

The Kentucky Obstetrical and Gynecological Society elected officers for the 1969-70 Associational year at a September 23 meeting during the KMA Annual Meeting.

Eugene A. Castle, M.D., Madisonville, was elected president of the Society. Other officers elected were John W. Greene, Jr., M.D., Lexington, president-elect, and Mervel V. Hanes, M.D., Louisville, secretary-treasurer.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1969-70

Officers

WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665 President
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 President-Elect
HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 Immediate Past President
DAVID A. HULL, 2368 Nicholasville Rd., Lexington (606) 277-5711 Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661 Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211 Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282 Vice-Speaker—House of Delegates
WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 Chairman of the Board of Trustees
THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 Jan. 1968-Dec. 1969
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1968-Dec. 1969
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1968-Dec. 1969
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1968-Dec. 1969

Trustees

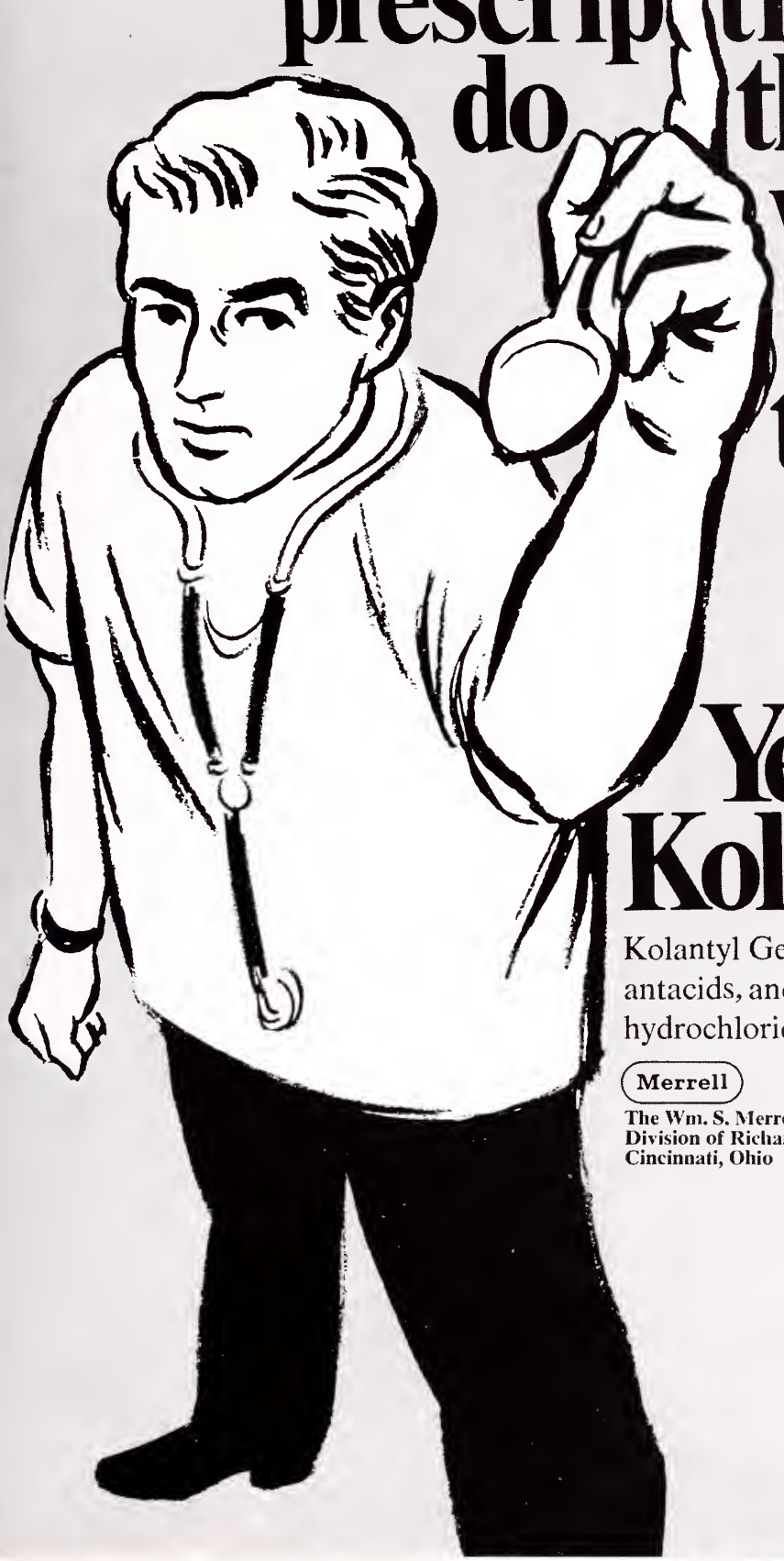
1st District C. C. LOWRY, 104 N. Fifth St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362 ..1971
5th District JOHN S. LLEWELLYN, 510 Heyburn Bldg., Louisville (502) 584-2173 1972
6th District PAUL J. PARKS, 1109 State St., Bowling Green (502) 842-0111 1972
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525 ..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1972
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231 1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406 1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751 1972
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155 ...1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616 ..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357 1972

Buyers Guide

NOVEMBER BUYERS GUIDE FOR JOURNAL OF KMA 1969

American Cancer Society 860
Arch Laboratories 862
Bristol Laboratories 830
Burroughs Wellcome 83S
Campbell Soup 827
Geigy Pharmaceuticals 796-797, 804, 838-839
General Leasing 86S
Highland Hospital 8S4
Hoechst Pharmaceuticals, Inc. 79S
Hynson, Westcott and Dunning 791
Lederle Laboratories 793, 810-811, 833, 861, 867
Lilly, Eli & Company 816
McNeill Laboratories 8SS
Merck Sharp & Dohme 806-808
Merrell, Wm., S., Company 869
National Drug Company 790, 799-800
Parke, Davis Company 8S8, 864
Pfizer Laboratories 8S6-8S7
Riker Laboratories 802-803
Robins, A. H., Company 849-850, 863, 866
Roche Laboratories 836-837, 870
Searle, G.D. & Company 828-829
Southern Optical Company 8S1
Strasenburgh Laboratories 812
Warner-Chilcott 843-844
Wyeth Laboratories 813-814

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

9-1243

(0715)



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg
and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, o summary of which follows:

Indications: Indicated when anxiety, tension and apprehensian are significant campanents of the clinical profile.

Contraindications: Patients with knawn hypersensitivity ta the drug.

Warnings: Caution patients abaut possible cambined effects with alcahol and ather CNS depressants. As with all CNS-acting drugs, caution patients against hazardaus occupations requiring complete mental alertness (e.g., aperating machinery, driving). Thaugh physical and psycholagical dependence have rarely been reparted on recommended dases, use cautian in administering ta addictian-prane individuals or those wha might increase dasage; withdrawal symptoms (including canvulsions), fallowing discontinuatian of the drug and similar to thase seen with barbiturates, have been reparted. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its passible hazards.

Precautions: In the elderly and debilitated, and in children aver six, limit to smallest effective dasage (initially 10 mg or less per day) ta preclude ataxio ar aversedatian, increasing gradually as needed and talerated. Nat recommended in children under six. Thaugh generally nat recammended, if combinatian therapy with ather psychotrapics seems indicated, carefully cansider individual pharmacalagic effects, particularly in use af potentiating drugs such as MAO inhibitars and phenathiazines. Observe usual precautians in presence af impaired renal or hepatic functian. Paradaxical reactians (e.g., excitement, stimulatian and acute rage) have been reparted in psychiatric patients and hyperactive aggressive children. Employ usual precautians in treatment af anxiety states with evidence af impending depressian; suicidal tendencies may be present and pratective measures necessary. Variable effects on bload coagulation have been reported very rarely in patients receiving the drug and aral anticoagulants; causal relatianship has nat been established clinically.

Adverse Reactions: Drowsiness, ataxia and canfusian may accur, especiolly in the elderly and debilitated. These are reversible in most instances by praper dasage adjustment, but are also occasionally observed at the lower dasage ranges. In a few instances syncope has been reparted. Alsa encountered are isalated instances of skin eruptians, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptams, increased and decreased libida—all infrequent and generally contralled with dasage reduction; changes in EEG patterns (law-voltage fast activity) may appear during and after treatment; blaod dyscrasias (including agranulocytasis), joundice ond hepatic dysfunctian have been reported occasianally, making periadic blood counts and liver functian tests advisable during protracted therapy.

VOLUME 67 DECEMBER 1969 NUMBER 12

The Journal of The KENTUCKY Medical Association

Season's Greetings



In This Issue

Carcinoma of the Colon in Childhood
Branham B. Baughman, M.D. 895

Hydroxyurea: A New Agent for the Management of Refractory Psoriasis
J. W. Yarbro, Ph.D and Ullin W Leavell, M.D. 899

Percutaneous Catheterization of the Subclavian Vein
Sam D. Weakley, Jr., M.D and E Truman Mays, M.D. 902

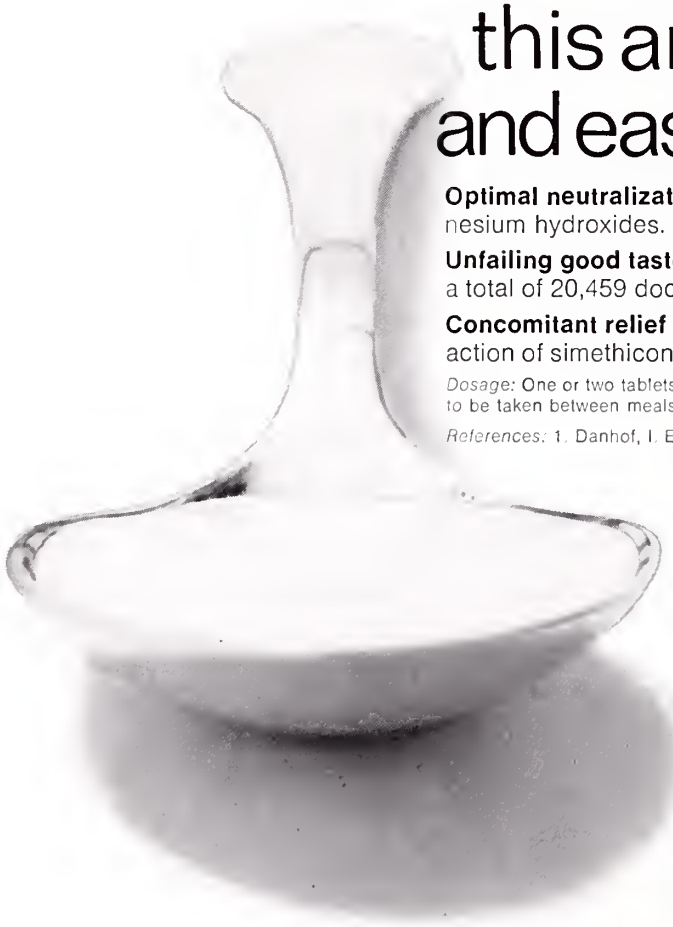
Digest of Proceedings, 1969 House of Delegates 914

Index to Volume 67 994

Complete Contents on Page 874

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

Volume 67 • December 1969

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Walter S. Coe, M.D.

• ASSOCIATE EDITOR
Sam A. Overstreet, M.D.

• ASSISTANT EDITOR
Walter I. Hume, Jr., M.D.

• MANAGING EDITOR
Robert G. Cox

• ASST. MANAGING EDITOR
Diane Moxey

• DEPARTMENTAL EDITORS
Charles C. Smith, Jr., M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscor J. Hayes, M.D., Case Discussions
Lewis Dickinson, M.D., Insurance

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1972
Richard R. Crutcher, M.D.
Chrisman S. Jackson, M.D.
E. Trumon Mays, M.D.
Joseph Parker, Jr., M.D.
Elmer G. Prewitt, M.D.
Carl E. Rutledge, Jr., M.D.
Winston Rutledge, M.D.
A. Franklin White, M.D.

Term Expires July 1, 1971
McHenry S. Brewer, M.D.
Louis O. Giesel, Jr., M.D.
Joseph Keith, Jr., M.D.
Arthur Lieber, M.D.
John W. Roddick, Jr., M.D.
Edward C. Shrader, M.D.
Elliott P. Stevens, M.D.
Chester B. Theiss, Jr., M.D.

Term Expires July 1, 1970
Douglas L. Atherton, M.D.
Keith M. Coverdale, M.D.
William R. Gray, M.D.
Peggy J. Howard, M.D
Roy A. Martin, M.D
Charles R. Perry, M.D
David C. Shipp, M.D.
John H. Willard, M.D.

Published at 3532 Janet Avenue,
Louisville, Ky. 40205
Phone (Area Code 502) 454-6324

Subscription $10 (Members $5)
Single copy $1
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

Journal of The KENTUCKY *Medical Association*

Contents

SCIENTIFIC ARTICLES

Carcinoma of the Colon in Childhood
Branham B. Baughman, M.D. 895

Hydroxyurea: A New Agent for the Management of Refractory Psoriasis
J. W. Yarbro, Ph.D. and Ullin W. Leavell, M.D. ..899

Percutaneous Catheterization of the Subclavian Vein
Sam D. Weakley, Jr., M.D. and E. Truman Mays, M.D. 902

EDITORIALS

Robert C. Long, M.D.
Walter S. Coe, M.D. 907

Medical Educational Television Is Here
Thomas L. Heavern, Jr., M.D. 907

A Thank You
Walter S. Coe, M.D. 908

SPECIAL FEATURES

Digest of Proceedings, 1969 House of Delegates Meeting 914

KMA Constitution and Bylaws 984

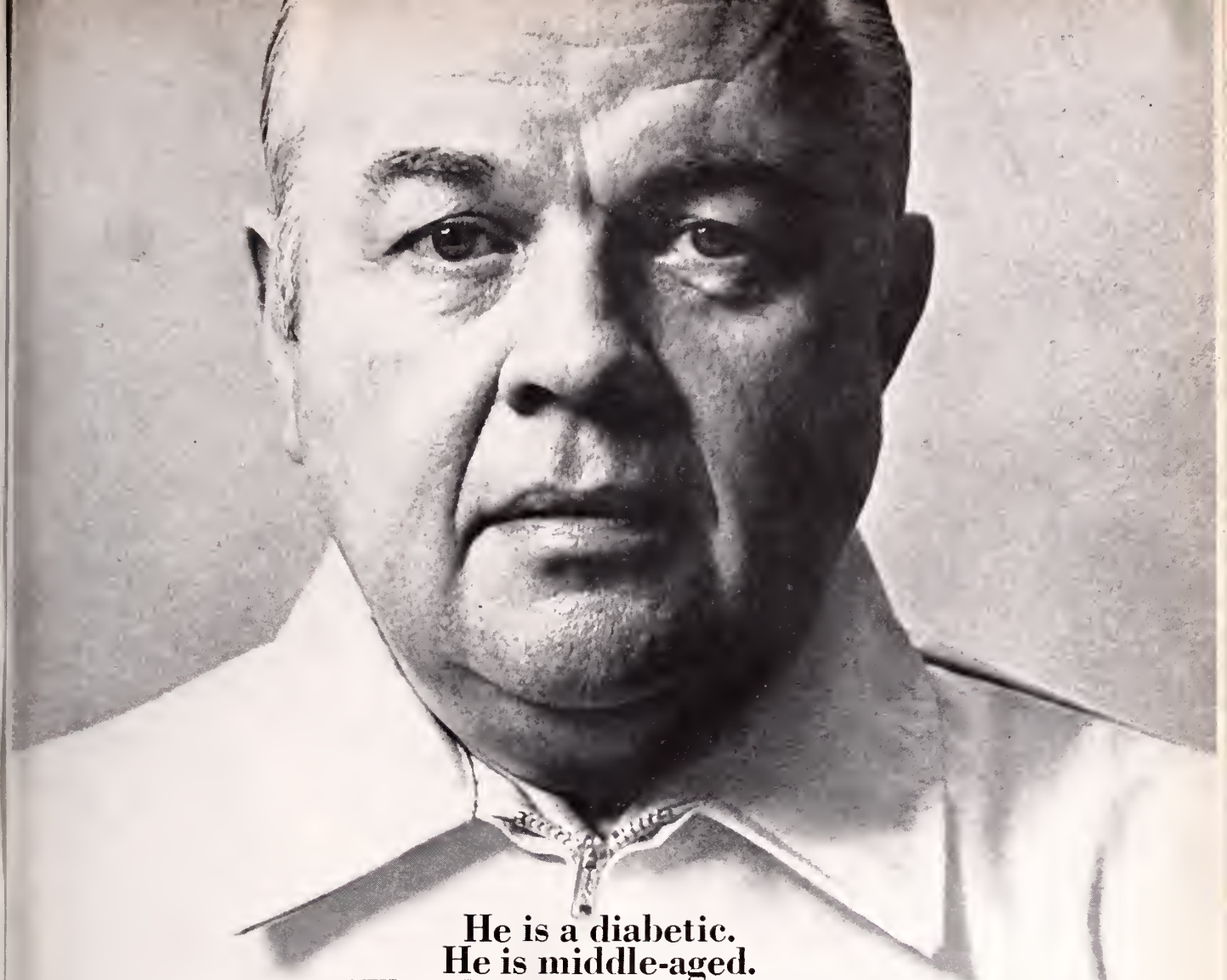
Index of The Journal for 1969 994

ORGANIZATION

Dr. Long Announces Candidacy for AMA President-Elect 965
J. Ed McConnell To Speak at 1970 Interim Meeting 965
KMA Surpasses 2400 Mark With Addition of 22 New Members ..966
Dr. C. Kenneth Peters Elected As KEMPAC Board Chairman 966
Book on Chiropractic Available to Kentucky Physicians 966
Dr. Seeley Represents KMA At U.S.P. Conference Oct. 20 966
KNA Elects President-Elect At 63rd Annual Convention 966
KMA Committees and Commissions for the 1969-70 Associational Year 967

REGULAR FEATURES

President's Page 878
Medical Progress 883
Maternal Mortality 885
Blue Shield Page 888
Postgraduate Opportunities ..913



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

L' ENVOI'

When Earth's last picture is painted, and the tubes are twisted and dried,
When the oldest colors have faded, and the youngest critic has died,
We shall rest, and, faith, we shall need it—lie down for an aeon or two,
Till the Master of All Good Workmen shall set us to work anew!

And those that were good shall be happy; and they shall sit in a golden chair;
They shall splash at a ten-league canvas with brushes of comets' hair;
They shall find real saints to draw from—Magdalene, Peter, and Paul;
They shall work for an age at a sitting and never be tired at all!

And only the Master shall praise us, and only the Master shall blame;
And no one shall work for money, and no one shall work for fame;
But each for the joy of the working, and each, in his separate star,
Shall draw the Thing as it sees It for the God of Things as They Are!

Rudyard Kipling (1865-1936)

Deceased Kentucky Physicians

1969*

Henry T. Alexander, Frankfort
George Franklin Archer, Louisville
Bernard Asman, Louisville
Everett Harold Baker, Louisville
Oscar Lafayette Barnes, Hopkinsville
R. D. Barton, Louisville
R. Lee Bird, Jr., Covington
Oscar Edgeworth Bloch, Jr., Louisville
Willis B. Blue, Henderson
Robert W. Brandon, Martin
William Mat Brown, Corbin
Jerome Lawrence Burke, Cleveland, Ohio
Henry C. Burkhart, Harlan
Max Caplan, Meridian, Conn.
Ivan Earle Carlisle, Michigan Town, Ind.
Benjamin D. Choate, Louisville
Charles Mason Cole, Bryan, Texas
Marcus Allen Coyle, Springfield
Maurice S. Davis, Frankfort
Milton Don Flanary, Pikeville
Morris Flexner, Louisville
Howard I. Frisbie, Stanford
William J. Frizzell, Dayton, Ohio
Joseph Gant Gaither, Hopkinsville
Edward D. Gibson, Pompano Beach, Fla.
Elton Bernard Gudenkauf, Lewisburg
Wilford Reeve Hansen, Louisville
E. M. Howard, Jr., Harlan
Thomas Kirby, Bowling Green
J. B. Lyens, Lawrenceburg
Nathan L. Marcus, Tampa, Fla.
James Oliver Mattax, Warren, Ohio
Walter Felix McCrocklin, Louisville
Edwin Francis Middlestadt, Louisville
Hazel Petrie Mosby, Rockford, Ill.
Vernon David Pettit, Paducah
James O. Pierce, Beechmont
Marinus Henry Pulskamp, Louisville
James Sears Rich, Lexington
Adam Mayfield Robinson, Louisville
Herbert E. Schoonover, Salem, Ill.
Charles E. Seibert, Dawson Springs
Elijah T. Sellers, Jacksonville, Fla.
Thomas A. Shannon, Lexington
Benjamin F. Shields, Shelbyville
Glenn M. Shifley, Paducah
Roy Silverthorn, Downey, Calif.
Ernest Gerald Skaggs, Paintsville
Raymond N. Stephens, Mansfield, Ohio
Henry Van Dyke Stewart, Carrollton
Jamie Campbell Thompson, Outwood
Gerald P. Tyler, California
William Lee Tyler, Owensboro
Charles E. Vidt, Ironton, Ohio
Kalman Scott Von Haitinger, Grosse Isle, Mich.
Thomas S. Wallace, Sr., Louisville
William Adair Weldon, Glasgow
Kenneth S. Welsh, Riverdale, N.Y.
Owen M. Wheeler, Louisville
Harold R. Wilber, DeLand, Fla.
Everett Cook Wilhite, Covington
Laban Robbins Wilson, Franklin
William C. Wolfe, Louisville
Ansel Clyde Worley, Plantation, Fla.

**List of names of deceased physicians available to The Journal as of November 15, 1969.*

MESSAGE FROM THE PRESIDENT



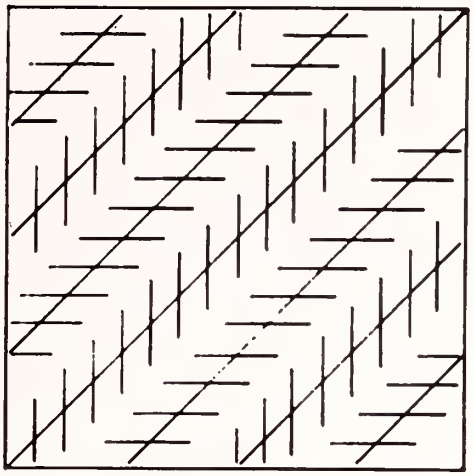
During this Christmas Season, please ponder the challenges of an onrushing and exciting decade. Let us join together in prayerful hope that the Almighty will give us the desire to take advantage of our opportunities.

The Officers and Staff of KMA join with me in extending to our members and their families, sincere best wishes for a Merry Christmas Season and a Happy and Healthy New Decade.

Walter L. Cawoof

OPTICAL ILLUSION?

All the long, diagonal lines are parallel, but the cross lines distract the eye and make them appear at angles. Don't suffer from the illusion that all glasses are properly crafted. Rely on SOUTHERN OPTICAL accuracy.



Charge accounts invited

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

Louisville

Bowling Green

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

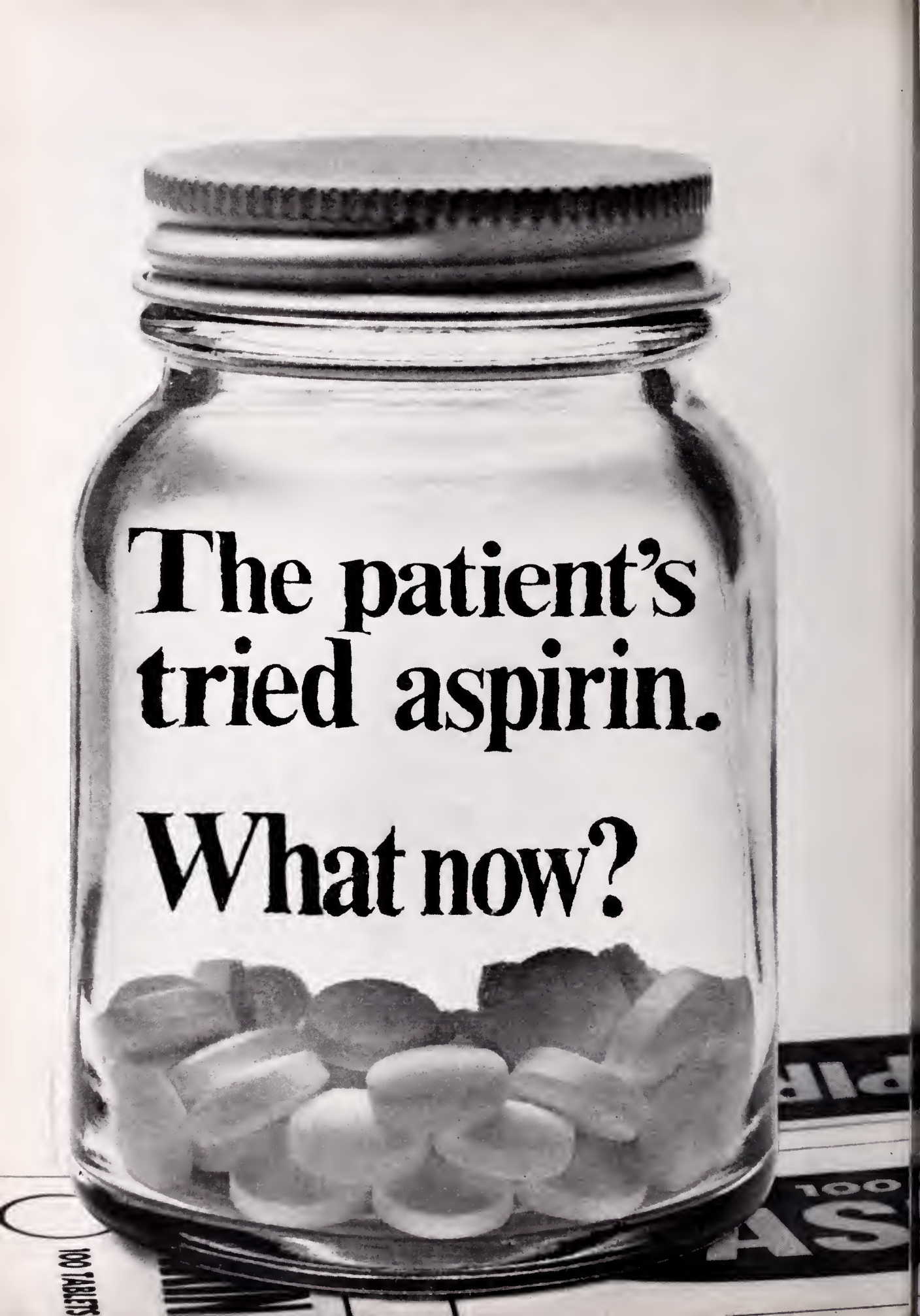
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully intregated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704-254-3201


The patient's
tried aspirin.
What now?
100 TABLETS

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

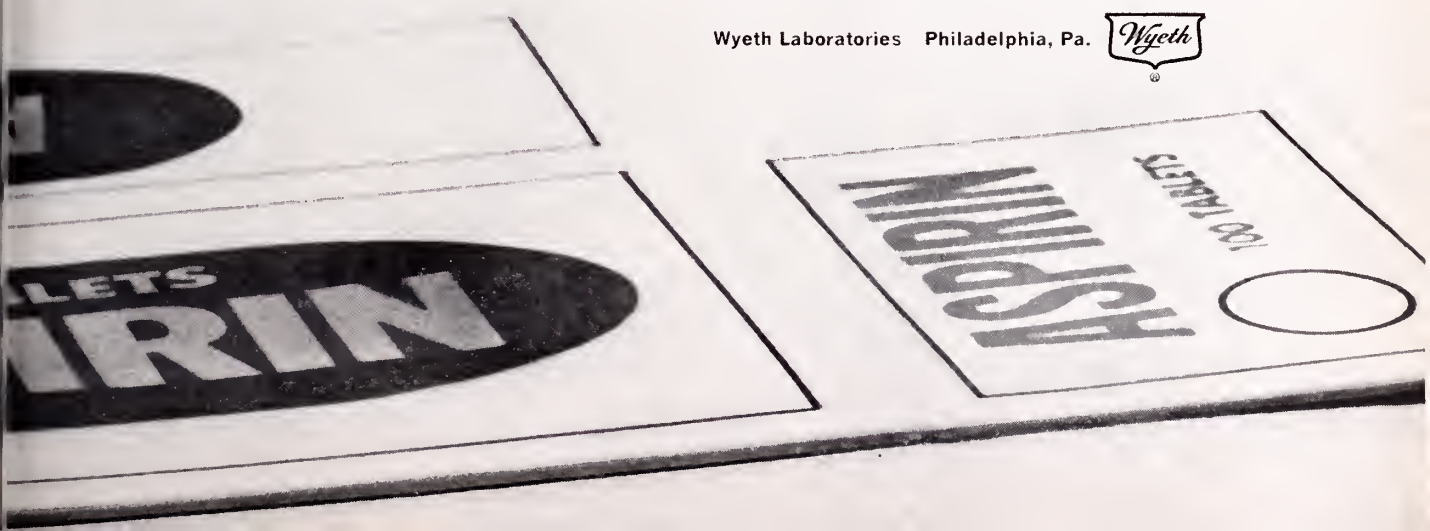
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



THE EDITORS AND STAFF OF THE JOURNAL OF KMA

Extend Sincere Thanks and Best Wishes To Our 1969 Advertisers for a Merry Christmas and a Happy New Year

American Cancer Society
American Medical Association
Arnar-Stone Laboratories
Arch Laboratories
Blue Cross-Blue Shield
Bristol Laboratories
Burroughs Wellcome & Company
Business & Professional Adjustment Service, Inc.
Cabell Huntington Hospital
Campbell Soup Company
The Continental Inn
Geigy Pharmaceuticals
General Leasing Corporation
General Motors, Frigidaire Division
Glenbrook Laboratories
Heart Association, Louisville & Jefferson County
Highland Hospital
Hoechst Pharmaceuticals, Inc.
Hynson, Westcott & Dunning, Inc.
William A. Johnson, M.D.
Kentucky Chapter, Arthritis Foundation
Kentucky Hotel
Kentucky Thoracic Society
Kentucky Travel Division
King's Daughters Clinic
Lederle Laboratories
Eli Lilly & Company
T. E. Lynn
Marion Laboratories
McNeil Laboratories
Medical Protective Company
Merck Sharp & Dohme
William S. Merrell Company
Mid-South Medical Association
National Drug Company
Parke, Davis & Company
Pfizer Laboratories
Pitman-Moore, Div. of Dow Chemical Co.
Wm. P. Poythress & Co., Inc.
Riker Laboratories
A. H. Robins Company
Roche Laboratories
William H. Rorer, Inc.
Sandoz Pharmaceuticals
G.D. Searle & Company
Smith, Kline & French Laboratories
Southern Optical Company
Strasenburgh Laboratories
Stuart Company
Veterans Administration
Wallace Pharmaceuticals
Warner-Chilcott Laboratories
Winthrop Laboratories
Wyeth Laboratories

WHAT'S NEW

in

Medical Progress

Antidepressant Drugs

ROGER K. WHITE, M.D.*

The past 15 years have seen many changes take place in the field of psychiatry. These changes are in great part due to the development of two groups of drugs, namely, the tranquilizers and the antidepressants. The development of these drugs has led to major changes in the practice of psychiatry and in the management of patients' emotional problems by all physicians.

Depression is a common problem in medical practice and may present itself in complaints of sleeplessness, weight loss, anorexia, "nervousness", or masked by a variety of physical complaints as well as presenting with a chief complaint of depression alone.

Prior to the late 1950's the only effective available treatment for depression was electroconvulsive therapy. This was, of course, limited to depressions of lesser severity which were treated with a variety of sedatives, tranquilizers and attempts at emotional support. These approaches were generally disappointing to both the patient and the physician, and generally resulted in many individuals remaining depressed for lengthy periods of time until the depression ran its course.

The first breakthrough in treatment of depression occurred in tuberculosis hospitals with the use of iproniazid (*Marsilid*). This drug, which was being used in the treatment of tuberculosis, was found to produce elation of even euphoria in many patients. When tried in depressed patients it was found to have a significant antidepressant effect which was later traced to its ability to inhibit the breakdown of the catecholamines. Unfortunately, iproniazid was found to have toxic side effects in the liver, and this led to a search for other chemical substances which would have the same pharmacologic effect. Several were developed; these include isocarboxazid (*Marplan*), nialamide (*Niamid*), phenelzine (*Nardil*) and tranylcypromine (*Parnate*). Clinical experience with these drugs soon showed that therapeutic effects could not be expected for 3-10 days in most patients and that the effects were quite subtle since the drugs rarely produced stimulation or euphoria in basically depressed individuals but rather led to the gradual disappearance or reduction of depressive symptoms without subjective side effects.

At about the same time a second group of antidepressant drugs was developed in conjunction with studies aimed at finding new phenothiazine tranquilizers. It was found that some of the derivatives of the basic phenothiazine chemical structure seemed to be more effective in relieving depression than in producing tranquilization in disturbed individuals. The first of these drugs were imipramine (*Tofranil*) and amitriptyline (*Elavil*). While they were found to be quite effective in many depressed individuals, they were found to produce some sedation as a side effect, which was quite useful in some cases, and they were found to have a somewhat slower onset of action when compared with the drugs which directly interfered with catecholamine breakdown. These drugs were found to frequently require one to three weeks before maximum benefit of the drug could be obtained. Experience with the two groups of drugs showed that they could not be safely given concurrently without a high incidence of hypotensive side effects.

Having at last an effective oral treatment for depressions, there was a great tendency to abandon electroconvulsive therapy completely and to treat all depressions with these various drugs. While in many cases of serious depression it became possible to avoid hospitalization and electroconvulsive therapy, it took considerable experience with the drugs to bring about the realization that, while they generally produce improvement in the symptoms, they did not always bring about a satisfactory return to a completely normal mood.

It was also found that these drugs did not compare favorably either in rapidity or relief or general predictable effectiveness in studies comparing them with electroconvulsive therapy. Because of the risk of suicide in significantly depressed individuals, the tendency recently has been to use the drugs in the mild to moderately depressed patients and to return to the use of hospitalization and electroconvulsive therapy in the more serious cases.

*Assistant Professor, Department of Psychiatry, University of Louisville School of Medicine, Louisville, Kentucky

The antidepressant drugs are far from being hazard free. It has been found that the monoaminoxidase inhibitors (i.e. the iproniazid group) could have hypotensive side effects of considerable magnitude. These side effects were felt to be most often associated with the concurrent ingestion of amphetamines, sympathominetic agents or considerable amounts of tyramine containing foods. The hypertensive crises, in particular, can be quite serious since they can lead to cerebral hemorrhage. Because of these risks, the drugs are now generally restricted in practice to use in intelligent, relatively young, cooperative patients who can be expected to avoid incompatible substances. The side effects of imipramine and amitriptyline are essentially the same as those seen with phenothiazine tranquilizers. These include atropine-like effects and a Parkinsonism-like picture.

The effective use of antidepressant drugs is far from a simple matter. The single most common therapeutic error is that of discontinuing the drug too soon. Most patients should remain on antidepressant medication for a period of several months after they have achieved complete relief of symptoms. If this is not done, many patients will revert back to their previous level of depression or a deeper level since the drugs do not in themselves "cure" the depression but merely control it.

The second most common error, especially in regard to the use of the imipramine and amitriptyline type of antidepressants, is the use of an inadequate dose in the initial stages of treatment. In these drugs 100 mg. per day is generally the *minimum* starting dose of the drug which may range upward to 200 mg. per day. Both the patient and his physician will be often dissatisfied with the response to these medications if only 50-75 mg. per day are given initially. In this same group of drugs the physician must keep constantly in mind the fact that the patient may have to be on the medication for one to three weeks before it can be properly determined just how much relief he can be expected to receive from the drug.

Used properly the antidepressant drugs can be an extremely effective therapeutic tool, but some patients will not get adequate relief from this more conservative method of management and will require hospitalization and electroconvulsive therapy. Even in these patients, some who tend to have recurring serious depressions may be able to obtain some prevention of the recurrences by maintenance use of the antidepressant drugs.

No currently known drug can replace electroconvulsive therapy in the cases of extremely profound depression and in other milder cases which do not respond to antidepressant drugs. During the past 15 years safer anesthetic agents and techniques have helped to minimize many of the side effects of electroconvulsive therapy and have tended to reduce the risks of this treatment. It should be recommended whenever no response or an inadequate response is obtained from the drugs.

The search for a better understanding of the mechanisms of depression and the search for new, more effective antidepressant oral medication continues. While none of the available drugs are free of hazard and while none will relieve all depressions, the realistic use of these medicines can provide a great deal of relief to the depressed patient and the often frustrated physican attending him.

One note of caution should be kept in mind in a drug treatment of depression—cerebral stimulants, especially the amphetamine group of drugs—have not been shown in carefully controlled studies to provide any significant relief from depression. These drugs generally will tend only to superimpose agitation on the depression, and this will compound the problem rather than relieve it. They also possess the additional disadvantage of being quite habit forming, especially in rather neurotic individuals. Their use in depression, therefore, is generally unwise.

May Your Holiday Season Be Filled With Happiness

Walter S. Coe, M.D., Editor
and the
Journal Staff

From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE I-68. This forty-year-old separated, gravida VI, para V, black female received prenatal care from the time she was three and one-half months pregnant. When initially seen, she exhibited anxiety about the pregnancy since she had been separated from her husband for a number of years. She had an elevation of her blood pressure, 160/100 and had moderately large saphenous varicosities. A vein stripping was done in 1961.

She was followed through the remainder of her pregnancy and a month prior to admission was observed to have a transverse lie. However, this converted to a cephalic presentation one week prior to her admission. Since she was eleven days past her expected delivery date, she was admitted to the hospital at 3:00 P.M. the 19th of March for induction of labor. Deep bilateral cervical tears and an old three degree laceration were noted. The cervix was described as three cms. dilated. A cephalic presentation at -2 station was present. Blood pressure was 156/98. She was given a barbituate and 1,000 ccs of D-5W with 1 cc of Pitocin was started.

At 5 p.m., the blood pressure was 138/90. At 5:55 it was 164/94. She complained of headache and received 50 mgs. of Demerol and 0.3 mg. of Scopolamine IV for this discomfort. At this time the cervix was 4 cms. dilated, -2 station. The fetal heart was good. She had a bloody show at 6:15, and complained of pain. Her pulse at this time was 160 and her physician was notified. She was seen by her physician at 6:20. She was 5 cms. dilated. She received another 50 mgs. of Demerol and 0.2 mg. of Scopolamine IV.

Her pulse at 6:30 was 124. She was 6 to 7 cms. dilated, the fetal vertex at +1 station. Her membranes were artificially ruptured; she was taken to the delivery room at 6:45 P.M. and given a saddle block when she was 7 cms. dilated. When placed in the supine position, following the block, it was noted that she was completely dilated and she appeared to be comatose.

The anesthesiologist gave 0.5 cc of Nalline IV. The patient remained unresponsive. She was placed in stirrups and an 8 pound 2 ounce girl was delivered spontaneously. The placenta was manually removed because there was noted to be a considerable gush of blood following the delivery of the baby. She continued to bleed in spite of the infusion she was receiving; an additional 1.0 cc of Pitocin was added to the IV. The uterus was massaged; a laceration of the cervix was repaired as well as a small laceration above the clitoris.

The uterus seemed to contract but would not remain firm. It was massaged with passage of 20 to 25 ccs of blood clots. Because of the presence of blood clots afibrinogenemia was not thought to be present. Her blood was typed and cross-matched. An angio-cath. was inserted and remained in the other arm to enhance the IV fluids and Oxytoxics. Methergine was given IM. Ringer's Lactate with 2 ccs of Pitocin was started.

The patient appeared to have respiratory obstruction, however, an air way did not seem to improve this. The expiratory phase of her respiration was prolonged and there was wheezing at both bases. Her blood pressure gradually fell from 110/70 to 80/60, in spite of blood being pumped in at a rapid rate. Her blood pressure was unobtainable. It was decided at this point to do a hysterectomy.

On entering the abdomen, an attempt was made to feel pulsations of the abdominal aorta. They were present. The bleeding was minimal at the time of the hysterectomy. In addition to blood, she received 5 grams of Fibrinogen with no noticeable improvement. There was a rather large hematoma noted in the region of the right infundibulopelvic ligament, however, before any definite effort could be made toward this, it was realized that the patient had expired. At 10:30 P.M. no pulsations were obtained in her abdominal aorta and the patient was pronounced dead.

An autopsy was obtained. There were no emboli or thrombi found in the portal veins or the vena cava or the pulmonary circulation. The absence of the uterus and the adnexal structures were noted. There was approximately 50 ccs of semi-liquid blood in the abdomen.

Positive findings were limited to the microscopic section. The lungs revealed extensive capillary dilatation with large amounts of erythrocytes in many areas. Alveolar collapse was prominent. The most striking microscopic observation was the presence of squames together with suggestive meconium in the small pulmonic vessels. Within the liver, centrilobular dilatation with engorgement by erythrocytes was seen within the parenchymal cells; fatty vacuolization was noted. Renal tubular necrosis at the cortical medullary junction was seen.

The pathological summary indicated the cause of death was felt to be due to amniotic fluid embolism.



When trauma results in pain, try Norgesic first... your patients probably won't need anything stronger

Sprains, strains, fractures... NORGESIC offers predictable relief in the great majority of traumatic injuries where both pain and muscle spasm are involved. Unlike "pure" analgesics or muscle relaxants, NORGESIC affects both components of musculo-skeletal pain, providing effective analgesia and relief of associated muscle spasm.

NORGESIC works quickly, usually producing a high level of analgesia within two hours, and relief is sustained for four hours or longer. Thus, when trauma results in pain, try NORGESIC first... your patients probably won't need anything stronger.

Indications: Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders. Here, NORGESIC demonstrated clinical superiority to APC as an analgesic.

Contraindications: Because of the mild anticholinergic effect of orphenadrine, NORGESIC should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy, obstructions at the bladder neck, myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.
USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when NORGESIC is administered to patients with renal disorders.

Adverse Reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, some degree of confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

Available V.A. Supply Depot—FSN6505-952-6762A



NORGESIC®
(orphenadrine citrate, 25 mg., aspirin, 225 mg., phenacetin, 160 mg., caffeine, 30 mg.)

Riker Laboratories, Northridge, California 91324
Sponsors of Riker Service—
the complimentary classified service for physicians.

Maternal Mortality

(Continued from page 885)

Acceleration of the coagulation process had occurred with associated fibrinolysis.

Comment

The Committee classified this as a direct obstetrical death due to amniotic fluid embolism. One cannot dogmatically state that this death was preventable. Possible preventable factors contributing to this maternal death were, the induction of labor in a woman that is a gravida VI and the artificial rupture of the membranes.

Amniotic fluid embolism has been observed to occur under such conditions. Pre-disposing factors in the causation of amniotic fluid seem to be tetanic uterine contractions, multiparity, and large infants. Some of these patients die undelivered with classical signs and symptoms of embolus. Others can survive the initial shock of the embolus but die within one to three hours after delivery.

Bleeding from mucous membranes and various organ surfaces is observed. Vaginal bleeding due to atony of the uterus secondary to the shock is frequently observed. Autopsy shows as this case did that amniotic debris is present in the pulmonary vasculature. The term amniotic infusion has been purported to be a better term than embolism, since the basic insult is believed to be intravascular clotting. The extent of this clotting and defibrination determines whether the patient dies immediately or recovers.

In a certain number of these cases where the insult is not massive recovery is possible. The administration of fibrinogen and blood may save the patient. An excellent series of papers by Reid *et al.* dealing with this entity is found in the *American Journal of Obstetrics and Gynecology* 66:465, 1953.

EMERGENCY ROOM PHYSICIAN — Accredited 280 bed progressive general hospital in beautiful Huntington, W. Va. Immediately available. Contact Assistant Administrator, Cabell Huntington Hospital, 1340 16th St., Huntington, West Virginia. A.C. 304 696-6590 collect.



ANSWERS TO YOUR QUESTIONS ABOUT BLUE SHIELD

Q. What is the Blue Cross and Blue Shield-65 supplementary program?

A. The Blue Cross and Blue Shield-65 supplementary plan is a program developed to supplement, but not to duplicate, the hospital, extended care facility, and medical benefits of the Medicare Program.

Q. Who is eligible for coverage under the Blue Cross and Blue Shield-65 supplementary program?

A. Each Kentucky resident who reaches age 65, is eligible for Part A and enrolls in Part B of the Medicare Program, may apply for coverage under the Blue Cross and Blue Shield-65 supplementary program. All applications must meet underwriting requirements except those from persons having a Blue Cross and Blue Shield contract which is in force at the time of application. (Enrolled members may automatically be transferred to the Blue Cross and Blue Shield-65 program regardless of health conditions.)

Q. How can Blue Cross and Blue Shield-65 members be identified?

A. If the subscriber's Identification Card contains the Blue Shield coverage code 95-95, this person has enrolled in the Blue Cross and Blue Shield-65 supplementary program.

Q. How should claims be filed when professional services are rendered to Blue Cross and Blue Shield-65 subscribers?

A. Each Blue Cross and Blue Shield-65 subscriber is provided with a special claim form and a brochure instructing them on how to file claims when enrolled. They are instructed to complete this simple form, attach itemized statements for covered services, and forward to Blue Shield's Louisville office. Each time the subscriber forwards a completed Blue Cross and Blue Shield-65 claim, additional claim forms are mailed from Blue Shield. Due to the deductible and co-payments involved, and the different providers of service covered under this program, payments are made directly to the subscriber.

Q. Should the regular Physician's Service Report be used for any Blue Shield member age 65 or older?

A. The physician is requested to file a claim with Blue Shield in the regular manner when the over-65 patient's identification card contains the Blue Shield Coverage Code 98-98, or the Group Number is 9068. These numbers denote a Carve-Out type program which does not duplicate Medicare benefits; however, allowances for this program will be paid direct to the physician.

Q. How may Blue Cross and Blue Shield-65 subscribers obtain assistance in filing claims?

A. The physician's office may feel free to assist these members in the filing of Blue Cross and Blue Shield-65 claims, or the member may receive assistance from any Blue Cross and Blue Shield office. These offices are located in Ashland, Bowling Green, Covington, Frankfort, Lexington, Louisville, Owensboro, Somerset and Paducah, and are open from 8:00 A.M. to 4:30 P.M. daily, except weekends and holidays.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN
depressants. As with all CNS-acting drugs, ca
tion patients against hazardous occupations r
quiring complete mental alertness (*e.g.*, operati
machinery, driving). Though physical and ps
chological dependence have rarely been reporte
on recommended doses, use caution in a
ministering Librium (chlordiazepoxide hydr
chloride) to known addiction-prone individua
or those who might increase dosage; withdraw
symptoms (including convulsions), followi
discontinuation of the drug and similar to tho
seen with barbiturates, have been reported. U
of any drug in pregnancy, lactation, or in wome
of childbearing age requires that its potenti
benefits be weighed against its possible hazard
As with all anticholinergic drugs, an inhibitin
effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate
limit dosage to smallest effective amount to pr
clude development of ataxia, oversedation c
confusion (not more than two capsules per da
initially; increase gradually as needed and tole

or here.



1). Though generally not recommended, if ıbination therapy with other psychotropics ns indicated, carefully consider individual rmacologic effects, particularly in use of po- iating drugs such as MAO inhibitors and nothiazines. Observe usual precautions in sence of impaired renal or hepatic function. adoxical reactions (*e.g.*, excitement, stimula- ı and acute rage) have been reported in psy- ıtric patients. Employ usual precautions in ıtment of anxiety states with evidence of im- ding depression; suicidal tendencies may be ient and protective measures necessary. Vari- : effects on blood coagulation have been orted very rarely in patients receiving the g and oral anticoagulants; causal relation-) has not been established clinically.

DVERSE REACTIONS: No side effects or ıifestations not seen with either compound ıe have been reported with Librax. When ɔrdiazepoxide hydrochloride is used alone, wsiness, ataxia and confusion may occur, ecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

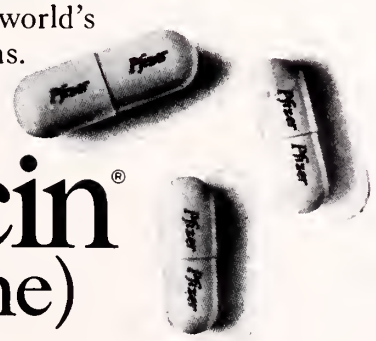
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
PINT (473 cc.) M-148
ILOSONE® LIQUID
ERYTHROMYCIN ESTOLATE ORAL SUSPENSION, U.S.P.
125
SHAKE WELL BEFORE USING
REFRIGERATE
AVOID FREEZING
ILOSONE® LIQUID
250
ILOSONE® CHEWABLE
125 mg.
100 PULVULES® No. 375
ILOSONE®
250 mg.
100 PULVULES® No. 374
125 mg.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
900761

The JOURNAL of the
Kentucky Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 67 DECEMBER, 1969 No. 12

Carcinoma of the Colon in Childhood†

BRANHAM B. BAUGHMAN, M.D., F.A.C.S.
Frankfort, Kentucky

A case of a 15-year-old boy with obstructive carcinoma of right colon is described. After many complications and operations he has survived three years without recurrence or metastases. A thorough review of the literature has been made.

In 1966 I reported the experience of a series of cases of cancer of the colon and rectum operated upon over the past 25 years. This disease continued to be the first or second leading cause of death from cancer in Kentucky, as well as in the United States, its rival being cancer of the lung.

My previous series of cases included two young men under 30, one 29 and one 28. Since the above series, I have operated on seven more patients, one of whom was a boy age 15. His case was rather unusual and rare; it is the subject of this paper.

Case Report

W. L. M., age 15, was seen in the emergency room of the King's Daughters Hospital on July 11, 1966. He first became ill on May 23, 1966, while at school, with cramp-like pains in the upper and mid abdomen. The pains were of short duration but recurred daily for about a week. There was no nausea or vomiting and the bowels were normal. He improved and felt well for two or three weeks. The pains recurred, became worse and diarrhea developed. He was seen by a physician and received medication. Symptoms continued and surgical consultation was advised. Bowels had not moved for three days prior to admission and nausea and vomiting had occurred. Pain was continuous at this time.

Physical examination revealed a tall thin boy of 15 in moderate discomfort, Temp. 99.0°. Abdomen revealed no scars, generalized distention, no masses, bowel sounds present and noisy. Rectal examination negative. RBC 4,800,000; WBC 6,200; Hb. 12.8; Stabs 18; Segs 54; L 26; M 2; Sed. rate 21. X-ray of abdomen: Distention of loops of small bowel with fluid levels. The impression was intestinal obstruction of unknown origin. The following morning a barium enema was given and the x-ray report was, "obstruction of the mid-portion of the ascending colon, due possibly to intussusception or tumor."

Shortly after this, the patient was operated on through a right rectus incision. Cloudy fluid was present and marked distention of the cecum and one-half of the ascending colon. The entire ileum was distended to a diameter of two to three inches. The cecum was enormous. Below the hepatic flexure a hard, irregular intraluminal mass was present. The liver appeared normal and no abnormal glands were found in the mesentery.

Because of the distention, the cecum was brought out through a McBurney incision and decompression was accomplished by a large mushroom catheter. Decompression was satisfactory and fairly rapid but fever and signs of peritonitis developed.

On July 24, 1966, the patient was reoperated. Extensive peritonitis was present, as

†*Presented before the Kentucky Surgical Society, Somerset, Kentucky, May 16, 1969.*

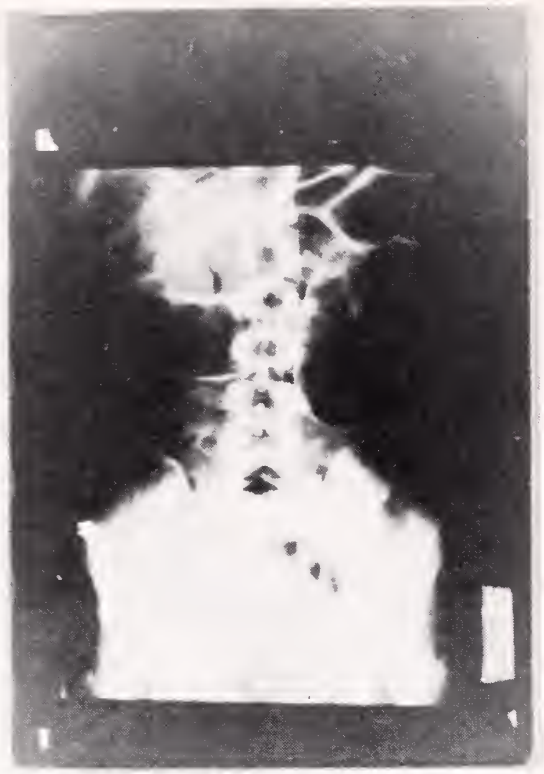


FIG. 1. Flat plate; day of admission; showing marked distension, due to complete obstruction in ascending colon.

well as a large pelvic abscess. Adhesions were freed, the abscess drained, abdomen irrigated, then a resection of the terminal ileum, cecum, ascending colon, hepatic flexure and part of the transverse colon was done and an end-to-end ileotransverse colostomy was performed, with a wide resection of mesentery. Because of the extensive peritonitis a Joel Baker tube was inserted in the proximal jejunum and threaded down to the anastomosis and fixed in place. The pelvis was adequately drained.

Pathological diagnosis: "mucinous annular adenocarcinoma with metastasis to three out of 15 nodes."

His course continued stormy. His bowels began to move promptly and continued to do so. The Baker tube was removed in nine days. Gastrografin by mouth passed rapidly through the small bowel and colon. On the 12th day signs of a small bowel obstruction developed, not relieved by Miller-Abbott tube.

He was reoperated, a pelvic abscess was drained and adhesions were freed. Two days later he was reoperated and a large hematoma was evacuated in the pelvis. He was discharged August 31, 1966, 51 days after admission. He returned to high school September 1966. By January, 1967, he had gained 30 pounds and was playing basketball. At this time, as on each succeeding January and July, he had a thorough examination, a liver scan and a chest x-ray, all of which showed no evidence of recurrence of metastasis. The most recent was June, 1969, at which time he weighed 175 pounds and was 6′ 2″ in height.

Comment

This unusual and complicated case has survived almost three years and is in apparent good health. Cancer of the colon in childhood is extremely rare[3]. In 1967 only 76 cases had been reported, excluding those associated with familial polyposis and ulcerative colitis. In seven of these the tumor arose from the cecum and all died within four months. Sherman et al reported a nine year old boy with a cecal cancer who appeared well one year after surgery[4]. Obstruction of the cecum and right colon is also rare, as reported by Thompson and Ward, only seven of their 26 cases showed obstruction[5]. Wilder et al of the Mayo Clinic found 20 cases over a 33-year period which showed obstruction from right colon cancer[6]. Obstructing cancer of the right colon carries a uniformly poor prognosis. Hickey and Hyde found only 11.5 per cent



FIG. 2. Barium enema day after admission showing site of obstruction in ascending colon.

five-year survival in this lesion[7]. Cancer in childhood also carries a very low survival rate[8].

Miller and Liechty had only six of 33 patients under 30 alive at follow-up and 17.8 per cent alive five years after surgery[9]. They had one patient aged 15 and another age 18. Almost 70 per cent of their patients were dead within two years after diagnosis.

Carrington Williams, Jr. reported three cases in children aged 15 and under, all of whom were dead in two years[10]. The longest survival which could be found was four years after operation reported by Webster.

Rankin and Comfort[11], at the Mayo Clinic from 1907 through 1926, found of all cases of cancer of the colon and rectum only one, aged 18, which was the youngest. They felt that the active tissues of youth, instead of resisting the invasion of cancer, invited its spread and that the young person has little chance for longevity.

Fowler[12] observed 21 patients under 26 years of age at the Mayo Clinic from 1914 through 1923 with colorectal cancer who had surgery. Sixteen of 19 traced had died by 1926.

Bacon and Sealy[13] in a review of 123 cases of cancer of the colon, rectum and anus in patients under 20 years of age, felt that there was no chance for cure.

Johnson et al studied 169 patients from 1925 through 1954, age 16 through 29, with adenocarcinoma at the Mayo Clinic. Ninety-five were operated on. Seventy-five were dead eight years after surgery. Four under 20 were living 10 to 20 years later.

Hoerner[15] in 1958 collected 73 cases of carcinoma of the colon and 189 of the rectum in patients under 20, published between 1865 and 1958.

Sessions and others[16] found 11 cases out of 761 from 1925 to 1960 under the age of 20. Only two of these lived as long as 44 months.

Ruderman[17] in 1960 reported the case of a boy, aged 11, with cancer of the ascending colon. He died within a year of operation.

Perkel and Alaghemond[18] reported six cases of cancer of the large bowel under 20 in 1962. Of these five died in less than a year. One, aged 10, lived three and one-half years and died.

Salem and Postlethwait[19] found five cases of carcinoma of the large bowel under 20 in



FIG. 3. Baker tube in place. Gastrograffin by mouth going promptly into colon.

the past 28 years at Duke Medical Center. One was alive at 16 months and the other 25 months after operation.

Obrien[20] in 1967 reported the case of a girl 16 with carcinoma of the sigmoid alive and well six years after resection. He states that this is the third long term survival in patients under 20 with carcinoma of the colon reported in the literature.

McSherry, Cornell and Glenn[21] in April, 1969, reported on 1625 cases of carcinoma of the colon and rectum. They had one patient age 20, which was the youngest, and 20 under the age of 30.

Summary

Cancer of the colon in children under 18 is extremely rare. A careful search of the literature reveals 76 cases. It is two or three times more common in the left colon than the right. Fifty per cent or more of cases are of the mucinous or colloid variety. Practically all cases have involvement of regional lymph nodes at the time of surgery. Survival is extremely rare. Three cases of long term survival have been found in the literature through 1967, one having lived eight years, one seven, and one four years after surgery.

My case is the fourth survival and the 77th case of cancer of the large bowel 18 years of age and under.

Survival after obstruction of the right colon is most unusual.

The diagnosis is usually made only at operation.

A case of cancer of the right colon with obstruction in a boy of 15, with numerous complications, with metastasis to regional nodes and with five operations is reported in detail. He has survived almost three years without evidence of metastasis, having been examined and having chest x-rays and liver scans made every six months and having gained 45 pounds since surgery. He appears to be in excellent health.

The treatment of the disease is similar to that in adults—radical resection of bowel and mesentery, with restoration of bowel continuity, in one-stage if possible, although at times, as in this case, a two-stage procedure for decompression may be required.

References

1. Baughman, B. B.: Cancer of the Large Bowel, *KMA Journal* (Aug.) 1967.
2. Ky. Vital Statistics, 1967, Ky. Dept. of Health.
3. Middelkamp, J. N., and H. Hoffner: Carcinoma of the Colon in Children, *Pediatrics*, 32:558, 1963.
4. Sherman, Neil J., John E. Yurko and John E. Jesseph: Adenocarcinoma of the Cecum in a Nine-Year-old Boy, *American Surgeon*, 33:745, (Sept.) 1967.
5. Thompson, Ronald W., and James B. D. Mark: Obstructing Adenocarcinoma of the Right Side of the Colon, *Arch. Surg.*, 96:100, (Jan.) 1968.
6. Wilder, T. C., M. B. Dockerty, and J. M. Waugh: A Clinical Pathologic Study of Obstructing Carcinomas of the Right Portion of the Colon., *Surg., Gynec. & Obstet.* 113:353-359, 1961.
7. Hickey, R. C., and H. P. Hyde: Neoplastic Obstruction of the Large Bowel, *Surg. Clin. N. Amer.*, 45:1157-1163, 1965.
8. Ariel and Pack: *Cancer and Allied Diseases of Infancy and Childhood*, Littleton, Brown & Co., 1960, Chapt. 23.
9. Miller, Frank E., and Richard D. Liechty: Adenocarcinoma of the Colon and Rectum in Persons Under Thirty Years of Age, *Am. Surg.*, 113:507-510, 1967.
10. Williams, Carrington Jr.: Carcinoma of the Colon in Childhood, *Am. Surg.*, 139:816-825, (June) 1954.
11. Rankin, F. W., and M. W. Comfort: Carcinoma of the Rectum in Young Persons, *J. Tennessee M. A.* 22:37-42 (June) 1929.
12. Fowler, L. H.: Malignant Epithelial Neoplasms, Carcinoma and Epithelioma Occurring in Persons Under 26 Years of Age, *Surg., Gynec. & Obstet.* 43:73-84 (July) 1926.
13. Bacon, H. E., and M. B. Sealy: Malignancy of the Anus, Rectum and Sigmoid Colon in the Young, *Am. J. Surg.* 45:339-347 (Aug.) 1939.
14. Johnson, J. W.: E. S. Judd and David C. Dahlin: A. M. A. *Arch., of Surg.* 79:365-372 (Sept.) 1959.
15. Hoerner, M. T.: Carcinoma of the Colon and Rectum in Persons Under 20 Years of Age, *Am. J. of Surg.*, 96:47, 1958.
16. Sessions, R. T.: D. H. Riddell, H. I. Kaplan and J. H. Foster: *Ann. of Surg.* 162:279-284 (Aug.) 1965.
17. Ruderman, Robert L.: *Canad. M. A. J.* 83:120-122 (July) 1960.
18. Perkel, Louis L., and Abbas Alaghemond: *Am. J. of Proct.* 13:170-172 (June) 1962.
19. Salem, Mohammed, and R. W. Postlethwait: Malignancy of Colon and Rectum in Patients Under 20 years of Age, *Ann. of Surg.* 151:335-337 (Mar.) 1960.
20. Obrien, S. E.: Carcinoma of the Colon in Childhood and Adolescence, *Canad. M. A. J.* 96:1217-1219 (Apr.) 1967.
21. McSherry, Charles R.: George N. Cornell and Frank Glenn: Carcinoma of the Colon and Rectum, *Ann. of Surg.* 169:502 (Apr.) 1969.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month —day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Hydroxyurea: A New Agent for the Management of Refractory Psoriasis†

J. W. Yarbro, M.D., Ph.D.* and Ullin W. Leavell, M.D.**
Lexington, Kentucky

Hydroxyurea is a new agent which is effective in the control of refractory psoriasis. The drug appears to have less toxic manifestations than methotrexate and is at least equally efficacious.

Psoriasis, although often mild, may on occasion produce an incapacitating dermatitis or a crippling arthritis which is refractory to conventional therapy. Furthermore, the emotional reaction of the patient, especially the female patient, to this disease may in itself be far out of proportion to the extent of involvement. Therefore, on occasion, in selected patients, one may justify the use of a therapeutic agent which carries more than the ordinary risk of side effects. One such agent, methotrexate, a folic acid antagonist, is currently in wide use.

In 1951, Gubner *et al.*[1] fortuitously discovered that psoriatic skin lesions cleared in a patient treated with aminopterin, a folic acid antagonist. Subsequently, Rees *et al.*[2, 3] reported excellent responses of psoriasis to this treatment. In 1958, Edmundson and Guy[4] reported the use of methotrexate, also a folic acid antagonist, but an agent with much less toxicity than aminopterin. Subsequently, methotrexate has been extensively used by a variety of investigators[5-15]. Its use, however, has consistently been associated with side effects of varying severity. Early in the use of folic acid antagonists for leukemia, hepatic fibrosis was observed[16] and this has been repeatedly confirmed[17, 18]. Recently, three patients receiving long-term therapy for psoriasis with methotrexate have been reported to develop cirrhosis[19]. Other adverse reactions associated with methotrexate therapy for psoriasis have also been reported, including malabsorption syndrome[12], candida septicemia with death[10], nausea, vomiting and leukopenia[14], stomatitis[15], and death from bone marrow depression[20]. Toxicity has been associated even with the very low dose regimens[15].

Because of its toxicity, methotrexate has been reserved for the severe refractory psoriatic patient and, even then, is used with some trepidation. Therefore, the availability of another agent less toxic, but equally effective, would be of considerable value in the management of these patients.

Although hydroxyurea was synthesized a century ago[21], it was not until recently that it was shown to be an effective agent in chronic myelogenous leukemia[22]. Hydroxyurea is a selective inhibitor of DNA synthesis[23] and this effect is rapidly reversible after therapy is discontinued so that the reduced white blood count produced by large doses returns promptly to normal[24]. Side effects have been minimal and platelet depression is less than with most other chemotherapeutic agents[24].

During the course of long-term therapy of chronic myelogenous leukemia with this agent, a peculiar thinning of the skin of the dorsum of the hands was noted. This observation, together with the effectiveness of methotrexate in psoriasis, led to a trial of hydroxyurea in psoriasis. The first two patients selected for study in 1965 showed a dramatic response to therapy[25]. This led to controlled double-blind clinical trials now in progress.

The purpose of this report is to present a patient with severe psoriasis who demonstrated dramatic improvement over a short course of therapy with hydroxyurea.

Case Report

A.V.S., (#1281120), a 71-year-old male was admitted to the University of Kentucky Medical Center with severe psoriasis of four years duration over his entire body, which was extremely pruritic, excoriated and bleeding,

†*Supported in part by a grant from the National Institute of Health No. CA 11266-02*
**Associate professor, department of medicine and director of the division of hematology and oncology, University of Kentucky Medical Center*
***Associate professor, department of medicine and director of the division of dermatology, University of Kentucky Medical Center*

and had been refractory to all conventional therapy, including a course of methotrexate given elsewhere. His past history and physical examination were essentially unremarkable except for obesity and the extensive psoriatic lesions. The entire body surface was covered with erythematous scaling lesions (Fig. 1) which varied between 0.5 and 6.0 cm in diameter. The scale was pearly white in color and, when removed, small pinpoint bleeders were noted. There was no undermining or friability of the nails. Over the legs, many of the lesions were confluent, forming large plaques. The skin was very dry and in some areas there were bleeding fissures and excoriations.

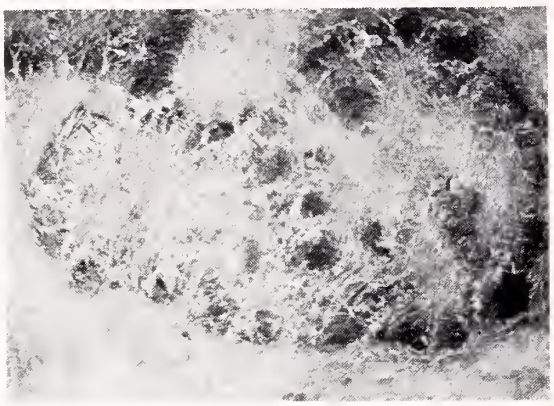


FIG. 1. This illustrates a typical elevated scaling annular lesion on the abdomen which measured 6.0 cm by 3.0 cm. The picture was taken before treatment with hydroxyurea.

Therapy was begun with hydroxyurea in a dose of 1 gm t.i.d. and continued for eight days. A transient leukopenia was observed with the white blood count returning to normal by the eighteenth day at which time therapy with hydroxyurea in a dose of 0.5 gm b.i.d. was begun. At no time did the patient develop nausea, vomiting or other side effects of therapy. Following institution of therapy, control of pruritus was immediate and response of the psoriatic lesions was dramatic. Each day a decrease in the scaling, elevation and erythema of the lesions could be seen. The fissures and bleeding cleared. Two weeks after hydroxyurea was started, the entire skin surface was clear except for a trace of the previously involved areas (Fig. 2).

Shown in Figure 3 is a skin biopsy taken at the time of initiation of therapy. This section shows marked thickening of the epidermis, parakeratosis, acanthosis and club-like downward projections of the epidermis.



FIG. 2. The same lesion as Figure 1 after two weeks treatment with hydroxyurea. The lesion is flat and there is no scale. Only a trace of the lesion remains.

Polymorphonuclear leukocytes may be seen in epidermal cells and a typical microabscess is present in the epidermis. Figure 4 illustrates a skin biopsy from the same site after two weeks of therapy. The dramatic thinning of the epidermis is seen. After hydroxyurea the epidermis was reduced to about one-fifth the pre-treatment thickness. By cell count the epidermis was reduced from 50 cells to 15 cells thickness. In the biopsy taken after treatment no parakeratosis, acanthosis, microabscess or increase in mitotic figures were seen. A summary of the dramatic clearing of clinical and pathological findings may be seen in Table 1.

Discussion

This case illustrates the excellent response and minimal toxicity which characterize the use of hydroxyurea in psoriasis.

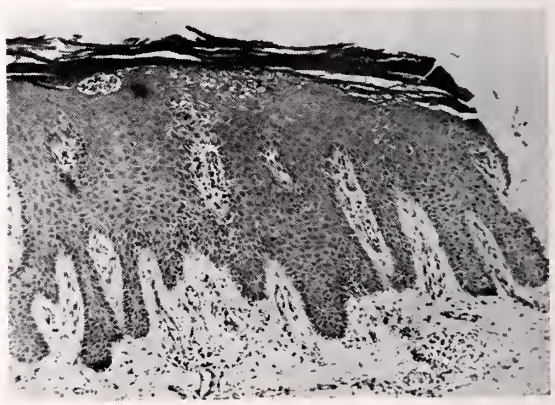


FIG. 3. Biopsy of a psoriatic lesion before treatment with hydroxyurea. There is parakeratosis, club-like acanthosis and marked thickening of the epidermis. Polymorphonuclear leukocytes are found inside epidermal cells forming small pustules. Occasional mitotic figures are seen. (Hematoxylin and Eosin x 90.1

It is not surprising that hydroxyurea, a specific inhibitor of DNA synthesis, should have this effect. Weinstein and Van Scott[26] have reported much faster growth of the epidermal cells in psoriasis than in normal cells. Whereas the time required for a cell after division at the base of the epidermis to migrate upward through the stratum malpighii is normally 13 days, in psoriasis this migration is accelerated to 48 hours. It is known that hydroxyurea is a potent inhibitor of skin growth in the mouse[27], and thus, the clinical response seen in patients with psoriasis is to be expected.

Two questions have yet to be resolved: First, is this agent more **selective** than methotrexate? That is, does it suppress growth of skin cells to a greater degree relative to other cells of the body than does methotrexate? And, second, the practical corollary of the above theoretical question: Will hydroxyurea produce less clinical toxicity than methotrexate? Laboratory and clinical investigations are currently in progress to answer these questions.



FIG. 4. Biopsy of a psoriatic lesion taken after two weeks treatment with hydroxyurea. The epidermis is about one-fifth as thick as it was before treatment. There is no parakeratosis, acanthosis or microabscess as were present before treatment.. (Hematoxylin and Eosin x 90.)

Finally, a note of caution: Hydroxyurea is a potent metabolic inhibitor and the absence of significant clinical toxicity to date does not preclude the possibility of complications if this agent is used indiscriminately in large numbers of patients. Psoriasis, regardless of its toll in human physical and mental suffering, remains a **benign** disease. Hydroxyurea, like methotrexate, should be used only in refractory cases, under careful observation of white blood count and other parameters, never in a woman who may become pregnant or a man who may father a child while on therapy, and only after a careful explanation to the patient of the potential risks associated with anti-metabolite therapy and the fact that such therapy is new and not standard.

TABLE I

Clinical and pathological alterations of psoriasis which cleared after two weeks of therapy with hydroxyurea.

Clinical changes of skin	Microscopic changes of skin
Elevation	Parakeratosis
Erythema	Epidermal Thickening
Scaling	Acanthosis
Fissures	Microabcesses
Bleeding	Increased Mitotic Figures

Summary

Hydroxyurea, an inhibitor of DNA synthesis, is an effective agent for the control of chronic myelogenous leukemia and acts by suppressing the rate of cell division. Psoriasis is associated with a rapid rate of cell division in the epidermis. A case of severe psoriasis, refractory to conventional therapy, including methotrexate, is presented in which excellent response was obtained with hydroxyurea given orally. Hydroxyurea may be less toxic in prolonged use than is methotrexate and may provide a valuable tool for the management of the severe psoriatic.

References

1. Gubner, R., August, S., and Ginsberg, V. Therapeutic Suppression of Tissue Reactivity; Effect of Aminopterin in Rheumatoid Arthritis and Psoriasis. *Am. J. Med. Sci. 221:*176-182, 1951.
2. Rees, R. B., Bennett, J. H., and Bostick, W. L. Aminopterin for Psoriasis. *A.M.A. Arch. Derm. 72:*133-143, 1955.
3. Rees, R. B., and Bennett, J. H. Further Observations on Aminopterin for Psoriasis. *J. Invest. Derm. 32:*61-66. 1959.
4. Edmundson, W. F., and Guy, W. B. Treatment of Psoriasis with Folic Acid Antagonist. *A.M.A. Arch. Derm. 78:*200-203, 1958.
5. Rees, R. B., and Bennett, J. H. Methotrexate versus Aminopterin for Psoriasis. *A.M.A. Arch. Derm. 83:*970, 1961.
6. Van Scott, E. J., and Reinertson, R. P. Morphologic and Physiologic Effects of Chemotherapeutic Agents in Psoriasis. *J. Invest.Derm. 33:*357-369, 1959.
7. Van Scott, E. J., Overbach, R., and Weinstein, G. D. Parenteral Methotrexate in Psoriasis. *A.M.A. Arch. Derm. 89:* 550-556, 1964.
8. Auerbach, R. Parenteral versus Oral Folic Acid Antagonists. *A.M.A. Arch. Derm. 90:*553-557, 1964.
9. Shrank, A. B., and Blendis, L. Folic Acid Antagonists in the Treatment of Psoriasis. *Brit. J. Med. 2:*156, 1965.
10. Roenigk, H. H., Haserick, J. R., and Curtis, G. H. Methotrexate for Psoriasis. *Cleveland Clin. Quart. 32:*211-215, 1965.
10. Rees, R. B. Methotrexate for Psoriasis. *A.M.A. Arch. Derm. 95:*2-11, 1967.
12. Stebbins, P. L. Methotrexate in Treatment of Psoriasis: Report of a Severe Reaction Secondary to Induced Malabsorption. *Bull. Mason. Clin. 21:*20-30, 1967.
13. Scott, R. B., and Surana, R. Erythrodermic Psoriasis in Childhood: Young Negro Child Treated with Methotrexate. *Am. J. Dis. Child. 116:*218-221, 1968.
14. Ziprkowsky, L., and Schewach-Millet, M. Treatment of Psoriasis with Methotrexate. *Harefuah* (Israel). *76:*414-415, 1969.
15. Spiro, J. M., and Demis, D. J. Treatment of Psoriasis with Minute Doses of Methotrexate. *A.M.A. Arch. Derm. 99:* 459-464, 1969.
16. Rice, E. C. Treatment of Leukemia in Children with Folic Acid Antagonists. *Clin. Proc. Child. Hosp. D. C. 6:*257-277, 1960.

(Continued on page 976)

Percutaneous Catheterization of the Subclavian Vein In Various Clinical Situations†

Sam D. Weakley, Jr., M.D. and E. Truman Mays, M.D.
Louisville, Kentucky

The subclavian vein is a constant and convenient site for percutaneous cannulization. The high volume flow rate in this vein prevents the usual complications of indwelling venous catheters. The subclavian catheter is a useful adjunct in promoting patient care and comfort.

In the practice of hospital medicine today, physicians utilize the venous circulation daily for administering fluids and medications, for withdrawing blood samples and for monitoring venous pressure. Surgical exposure of a vein and the insertion of a catheter is often necessary when simple venipuncture cannot be accomplished. The introduction of the polyethylene catheter in 1945 provided a stable and durable route to the venous circulation. The availability of commercially prepared needles and sterile catheters for percutaneous insertion has greatly increased the use of the polyethylene venous catheter. Busy physicians and house officers have found the "angiocath" and "intracath" extremely helpful and timesaving devices.

Although an integral part of patient care, these procedures all have their complications. "Cutdowns" nearly always become infected[1]. Catheter sepsis is a major problem in hospital medicine[2, 3]. Thrombophlebitis is frequent and the hazards of thrombo-embolic phenomena are always present. Patient discomfort from prolonged immobilization and splinting of the extremities is distressing. Infusion of hypertonic solutions in peripheral veins causes chemical irritation, thrombosis, and chemical necrosis. To prevent these unfortunate and dangerous complications, large veins with high volume flow must be utilized.

The purpose of this paper is to focus attention on the subclavian vein as a constant and convenient site for percutaneous cannulization and to recommend this technique as a valuable tool in patient care and management.

Anatomy

The subclavian vein begins at the outer border of the first rib and unites with the jugular vein behind the sternal end of the clavicle to become the brachiocephalic (innominate) vein. In front it is intimately related to the medial third of the clavicle and the subclavius muscle. The anterior wall of the vein is united to the fascia of this muscle. The subclavian artery is behind and slightly above. Both the artery and vein are closely related as they lie in their respective grooves on the superior surface of the first rib. They are separated from each other medially by the anterior scalene muscle.

Near its termination it is united to the middle layer of deep cervical fascia behind which it lies. As a result of these connections the vein does not collapse and its lumen is enlarged by movements of inspiration and raising the arms. These relationships emphasize the enclosure of the vein throughout its length by rigid structures that prevent the rolling, collapse and escape which makes venipuncture of the external jugular and other peripheral veins so very difficult at times.

The brachial plexus is behind and above and separated from the vein by the subclavian artery. The dome of the pleura is behind the artery and separated from both the artery and vein by Gibson's fascia—a coarse domelike expansion of fascia and muscle fibers extending from the inner border of the first rib over the cupola of the parietal pleura and attached behind to the anterior border of the transverse process of the seventh cervical vertebra.

Technique

Familiarity with the anatomy of the subclavian vein is an absolute prerequisite. Those

†*From the department of surgery, University of Louisville School of Medicine and the Baptist Hospitals, Ogbomosho, Nigeria and Louisville, Kentucky. Presented before the combined meeting of the Kentucky Surgical Society and the Kentucky Chapter of the American College of Surgeons, Somerset, Kentucky, May 16-17, 1969.*



FIG. 1. Supraclavicular approach to the subclavian vein. a.) 45° angle with the midsagittal plane. b.) 15° angle with the coronal plane.

who undertake this procedure should have, somewhere in their careers, experience in cadaver dissection. Paramedical personnel without experience in anatomical dissections should not undertake this procedure. Aubainac[4] first introduced this technique in 1952. There are two sites at which each subclavian is readily accessible for percutaneous cannulation. One is a supraclavicular approach and the other infraclavicular. This means that on every patient there are four sites for subclavian catheterization.

A small sterile tray contains towels, a 2-inch 14 gauge, thin-wall Becton-Dickinson needle; a 5 or 10 cc. syringe; a 12-inch length of polyethylene catheter (Intramedic P.E. 190 Clay-Adam, Inc., New York, New York); and a blunt-tipped needle to fit into the end of the catheter. An alternate method that we have begun to use more and more, utilizes the Deseret Intracath which has a 14 gauge, two inch needle. (C.R. Bard, Inc., Murray Hill, N.J., catalogue no. 1514.) This set comes as a sterile unit ready for use and has the advantage that the catheter is radiopaque.

The patient should always be lying flat in a slightly head-down position. The head is slightly extended and turned to the opposite side. This makes the cleidomastoid-clavicular angle obvious. The 14 gauge needle is inserted at the apex of this angle at 45° away from the midsagittal plane. The barrel of the syringe is depressed 10-15° below the midcoronal plane and the needle advanced. (Fig. 1) The stylet is removed after penetrating the skin and gentle suction applied on the syringe as the needle is advanced into the vein. A free flow of blood indicates successful puncture. The syringe is removed and the thumb placed over the hub of the needle. The polyethylene catheter is threaded through the needle into the vein and the needle removed, allowing the catheter to remain behind in the vein. For the infraclavicular puncture a site is chosen at the midpoint of the clavicle and the needle passed slowly beneath the clavicle parallel to the bed or midcoronal plane aiming the tip of the needle to a point 2 cm. cephalad to the sternal notch. (Fig. 2) The syringe is gently aspirated as the needle is advanced until a sudden free flow of blood is obtained and the catheter inserted.

Once the catheter is in place it is connected to a venous monitor or intravenous drip. The catheter is anchored to the patient by tearing a 2-inch adhesive strip down the center to form a "Y". One limb of the "Y" extends up onto the polyethylene cannula to completely surround and secure it permanently. The other limb of the "Y" extends on across the clavicle and shoulder. Additional cross straps of adhesive secure the "Y" to the chest wall. If it is not desirable to administer fluids or monitor pressure, catheter patency is maintained by attaching a syringe filled with saline and anchoring it to the anterior chest wall with adhesive strapping. Serial venous blood samples are drawn when indicated.

It is advantageous to both physician and patient that he become familiar with the supraclavicular and infraclavicular approach. Some advocate one approach to the exclusion of the other, but we believe that one should be thoroughly familiar with both the supra- and infraclavicular approach. If unable to puncture the vein on one or two passes, a new site should be selected and a new attempt

made. Most thin patients permit easy success from any of the four sites mentioned. In the very obese patient, a fat pad may be present between the subclavius muscle and the vein. In such instances allowance must be made in the infraclavicular approach and the needle inserted at approximately a 45° angle rather than parallel to the coronal plane.

Clinical Material

Our experience with this procedure consists of 112 successful catheterizations and four attempts to pass the catheter into the subclavian vein that were unsuccessful. Complications from this procedure have been minor. There were four inadvertent punctures of the subclavian artery. There were no serious sequelae in any. More serious complications have been reported. These consist of hemothorax, tension pneumothorax, subcutaneous emphysema, brachial plexus injury, septicemia, intrapleural administration of fluids, puncture of subclavian artery, subcutaneous hematoma and catheter embolus[5, 6, 7].

We simply wish to point out that ours is a personal series in which all catheters were placed by one of the two authors, that meticulous care was taken in placement and maintenance of these catheters, and that the anatomical planes and angles outlined under "Technique" were adhered to strictly. This is the only explanation we offer in explaining our small number of insignificant complications.

We present three of our patients in a very brief manner in order to illustrate the various kinds of clinical situations in which this procedure is helpful to the physician.

Case I: L.M.G., age 68, was admitted to the Kentucky Baptist Hospital on October 28, 1968, with the complaint of abdominal cramping pain. His abdomen was slightly distended and tympanitic. Blood pressure was 130/80 mm. Hg. A urinalysis showed 30 to 40 wbc. and the urine culture produced 2,500 colonies of *E. coli*.

The patient was uncooperative and refused a colon study with barium. On November 2, he had a sudden shaking chill, spiked a temperature of 103° F, became confused and developed diarrhea. Hypotension and oligemia followed quickly. A blood culture grew *E. coli* and the sensitivity pattern was the same as the *E. coli* cultured from the urinary tract.

A subclavian catheter was inserted and large volumes of saline solutions were administered rapidly while monitoring the central venous pressure. Sodium cephalothin and hydrocortisone sodium succinate were added to the fluids. He responded with an improvement in circulation and urine output, and the temperature came down slowly.

On November 7, 1968, he had a similar episode of hypotension, oligemia and fever after a shaking chill, and again had positive blood cultures for *E. coli*. The subclavian catheter was still in place and he was treated in exactly the same manner as five days before during the first episode of gram-negative septicemia. Again he responded to this management and by November 13 he was afebrile, taking an oral diet, and doing well. He persistently refused suggestions for investigative examination and finally signed out of the hospital against medical advice. The subclavian catheter remained in situ ten days without evidence of thrombophlebitis or thrombo-embolic phenomena.

Case II: J.K., age 71, male, Kentucky Baptist Hospital #450-842. This elderly gentleman was admitted September 14, 1968, in hemorrhagic shock caused by rupture of an abdominal aortic aneurysm. His abdomen was distended and tender. Blood pressure in the arm was 60/40 mm. Hg. and his skin was moist and clammy. In the operating room under general anesthesia the aneurysm was resected and the terminal aorta reconstructed with a knitted dacron bifurcation graft. He received four units of blood during this procedure. A large Meckel's diverticulum was resected at this time also.

During the first 24-hour period his urine output was 970 cc. and peripheral pulses distal to the arotic graft were bounding and full. In the next 24-hour period his urine output was 202 cc. and he had a marked hemoglobinuria with a metabolic acidosis (blood pH 7.29, CO_2 64 vols per cent, BUN 68 mg per cent, K 4.9 meq./L). It was felt that this represented the response of shocked kidneys to a mismatched blood transfusion. A subclavian catheter was inserted percutaneously and 500 cc. of 50 per cent dextrose given slowly over a 24-hour period to provide maximum calories for protein sparing effect with limited fluid replacement. Sodium bicarbonate was given to correct the metabolic acidosis

and nandrolone phenpropionate to obviate protein breakdown. He was digitalized with deslanoside.

The third postoperative day fluids were again restricted and calories administered by 500 cc. 50 per cent dextrose. His hourly urine output ranged 5-9 cc. Plans were formulated to insert a temporary external silastic arteriovenous shunt in the forearm to be used in hemodyalysis since all signs pointed to acute tubular necrosis.

However, by the fourth day he entered the diuretic phase and his 24-hour urine output increased to 1037 cc. He was still acidotic (pH 7.2) and uremic (BUN 108). Serum potassium was 4.8 meq./L. Sodium bicarbonate and 500 cc. of 50 per cent dextrose were again administered intravenously. His diuretic phase continued on the fifth, sixth and seventh hospital days. The urine output was replaced with intravenous physiologic saline. His BUN rose to a peak of 134 by the sixth day and then began to subside. Serum potassium never rose above 4.9 meq./L. He was discharged on October 3, 1968, with strong lower extremity pulses and a BUN of 58. Three months later his BUN was 22 and Creatinine, 1.8. Nine months later he was asymptomatic and mowing his lawn without claudication.

Case III: H.O., age 65, female, Ogbomosho Baptist Hospital. This African lady was admitted as an emergency in April, 1967. She had acute onset of severe epigastric pain a week before admission. The pain has subsided slowly but increasing dyspnea and orthopnea developed followed by ankle edema. She had a tachycardia of 140 beats per minute and temperature of 101° F. Moist rales were present in both lung fields posteriorly. She was dyspneic in a sitting position. The abdomen was slightly distended and there was exquisite tenderness in the right upper quadrant with spasm of the abdominal musculature localized in this area. A leukocytosis was present and a mild anemia.

A subclavian catheter inserted percutaneously showed the central venous pressure (CVP) to be 30 cm. saline. Deslanoside 0.8 mg. was administered intravenously and the CVP monitored. Right atrial pressure fell rapidly to 6 cm. saline within 15-30 minutes and the patient was able to comfortably lie supine without respiratory distress. Heart rate slowed to 100 beats/min. She was taken to the operating room and a spinal anesthetic given in the lumbar area. This was supplemented by intercostal nerve blocks. A cholecystectomy was accomplished through a right subcostal incision. The gallbladder was acutely inflammed. The wall was thick and whitish-gray with areas of erythema and petechicial hemorrhage. Some areas were becoming ischemic with impending gangrene.

Her postoperative course was uneventful. Additional deslanoside was given in 0.4 mg. increments at 8-hour intervals. The subclavian catheter was removed after seven days. She showed no further signs of cardiac decompensation and was discharged home by the eighth postoperative day.

Comment

All of us have witnessed the discomfort of a patient immobilized for long hours with the arm strapped to a board while an incessantly slow drip of intravenous fluids monotonously irritates the patient to the point of exhaustion. By using the subclavian catheter, patient discomfort from prolonged immobilization is no longer a problem because complete freedom of movement of the hands and arms is per-



FIG. 2. Infraclavicular approach. a.) needle and syringe are parallel to patient or bed (coronal plane) and the patient is supine with head turned to the right. b.) the needle is directly toward the sternal notch or slightly above and advanced beneath the clavicle.

mitted. Other indications are outlined in Table 1.

The first case illustrates the efficacy of the subclavian catheter in administering large volumes of fluids rapidly in patients with septic shock while monitoring the central venous pressure to avoid overloading the vascular space. This patient had two separate episodes of gram-negative shock in which *Escherichia coli* was cultured from the blood stream. The catheter was also convenient for administering an antibiotic (sodium cephalothin) that in peripheral veins has a high incidence of chemical necrosis.

TABLE I

Indications

1. Massive and rapid replacement of blood and fluids.
2. Prolonged intravenous therapy.
3. Parenteral "hyperalimentation."
4. Monitoring central venous pressure in patients with marginal cardiac reserve or acute circulatory failure.

The second case is just the opposite from the first in that fluid restriction was indicated in the face of renal failure but calories were needed to prevent excessive protein breakdown with hyperpotassemia and elevated blood urea nitrogen. Fifty per cent dextrose given in peripheral veins usually causes severe chemical phlebitis. It is administered through the subclavian without evidence of complications. In this way a small volume of fluid but a high concentration of solute can be provided without undue trepidation. Others have utilized this same concept in patients requiring "parenteral hyperalimentation".

The third case is extremely interesting and points out the usefulness of the subclavian catheter in situations where emergency surgery is indicated but associated cardiac decompensation prevents the accomplishment of such surgery. In this particular situation, the acute gangrenous cholecystitis was aggravating the heart failure because prior to her surgical disease the patient had performed the normal task of life in a borderline situation without the aid of a cardiac glycoside. The use of short-acting desolanoside while monitoring CVP via subclavian catheter produced an almost immediate improvement in cardiac function and the patient's clinical condition reflected this by her ability to assume a supine position without respiratory distress. The sympathetic blockade secondary to spinal anesthesia and the resultant vessel dilatation and pooling in the lower half of the body acted as a "physiologic bleeding" to reduce circulating blood volume and make the work of the heart easier.Her rapid and continuous improvement in cardiac dynamics after cholecystectomy clearly demonstrated that intra-abdominal disease had compromised the borderline cardiac reserve in this particular patient. The continuous monitoring of CVP via subclavian catheters in patients with overt or borderline heart failure gives useful information that aids the physician in timing and planning laparotomies in emergency circumstances.

The importance of monitoring central venous pressure has been clearly demonstrated in many clinical situations. Time does not permit us to enter into a discussion of the importance of this technique. We simply point out the inconvenience of cutting down on the antecubital fossa and threading a long catheter through the basilic-axillary-subclavian-inominate system into the superior vena cava in order to obtain a truly central venous pressure. Subclavian catheterization obviates these difficulties and a short catheter is rapidly inserted into the superior vena cava where a veritable CVP can be monitored.

This procedure is worthwhile for both the large university medical center and the small community hospital. The advantages are listed in Table 2. It is less time-consuming than a "cutdown". All the hazards of the antecubital cutdown and peripheral venous catheters are avoided by utilizing percutaneous cannulation of the subclavian vein. The high volume flow

TABLE II

Advantages

1. Simple, rapid bedside procedure.
2. Eliminates surgical "cutdowns".
3. Immobilization and restraint of extremities not necessary.
4. Avoids painful hematomas, phlebitis and edema of the arms.
5. Prolonged intravenous therapy possible, even with hypertonic solutions.

rate effectively prevents thrombosis, sepsis and thrombophlebitis. Hypertonic solutions can be administered safely because of the immediate dilution and mixing with a large volume of venous blood. Serial venous blood samples are withdrawn as indicated without the repeated punctures of peripheral veins, avoiding painful phlebitis and hematomas of the arms. The simplicity of inserting a catheter into the superior vena cava by percutaneous

(Continued on page 975)

EDITORIALS

Robert C. Long, M.D.

THIS issue of The Journal carries a news item announcing the candidacy of Robert C. Long, M.D., Louisville, for the office of President-Elect of the American Medical Association. The news item does not give all the details of Doctor Long's medical career, but it indicates in part the exceptional and broad experience in medicine which he has achieved since he first entered the private practice of medicine. He has held many offices of responsibility in his community and at the state and national levels.

The bare facts of the news item do not convey the personal qualities which have made Doctor Long a successful leader in medicine at all levels of organization. Those physicians who have worked with him in his own community have been impressed with his energy, his willingness to assume difficult assignments and his attention to organizational detail. Doctor Long has other qualities which are found in many outstanding leaders; one of these is poise, or as the younger generation says it, keeping his cool when the going gets rough. Another of these qualities is a good sense of humor. Humor often helps to keep things in proper perspective.

There likely will be other candidates for the office of President-Elect of the American Medical Association, but we do believe that Doctor Long's professional experience and personal attributes uniquely qualify him for this office.

He has an established record of successful leadership and will make an excellent President.

His election to this office will reflect favorably on Kentucky Medicine. It would go beyond this in that the entire State of Kentucky would be benefited. However, it is primarily in the interest of American Medicine that we wish Doctor Robert Long well in his candidacy.

WALTER S. COE, M.D.

Medical Educational Television Is Here

KENTUCKY physicians and other health professionals have a unique tool at hand for expanding their medical knowledge. Medical educational television is a reality. Since October 6, weekly programs related to medical subjects have been telecast to virtually every corner of the State.

KMA is happy to be associated with the University of Kentucky and the University of Louisville in producing these programs. Advancing the knowledge of all physicians in the state, even those many miles removed from teaching centers, has been a pursuit of KMA since its formation in 1851. Now television, the 20th century gap-bridger, joins the chase. We welcome it!

Without the liberal assistance and technical expertise of the Kentucky Educational Television Network and University of Kentucky Television and WKPC-TV, Channel 15 Louisville there could be no effective program. Without the generous financial help of the Kentucky Heart Association and the Kentucky Division, American Cancer Society, it's unlikely that there could be any program at all. We sincerely thank all of them!

But, without an audience, all of this will amount to nothing. No tool is useful until someone picks it up. Weekly broadcasts are described on the Continuing Education page. They are designed for you, the Kentucky physician. Examine them! This is your opportunity to help determine how this new aid can be shaped to fit your needs so that when you "Tune in PANMED, it'll turn you on".

THOMAS L. HEAVERN, JR., M.D.

A Thank You

ANOTHER year has swiftly passed and The Journal comes to its sixty-seventh Christmas season. This has been another busy year for most Kentucky physicians. New problems and new challenges take the place of old ones and that is the way it will continue to be. Nineteen sixty-nine has been a good year for The Journal.

Doctor Charles Smith continues to do a fine job as Scientific Editor. Many excellent scientific articles were published during the year. Our thanks to the authors who submittted these papers. Our scientific consultants have continued during the year to serve The Journal in an effective and conscientious manner.

During this past year Doctor William Hall resigned as Insurance Editor after serving The Journal exceedingly well in this position for a number of years. His work has been assumed by Doctor Lewis Dickinson of Glasgow.

Many physicians throughout the Commonwealth have supplied The Journal with items of special interest to Kentucky physicians and we take this opportunity to thank them.

At this time of the year we give our special thanks to the companies that advertise their products in The Journal. All Kentucky physicians will join the editors in expressing our gratitude for their continued support.

To all of these our thanks and our best wishes for a Merry Christmas and a Happy New Year.

WALTER S. COE, M.D.

Make Plans Now To Attend

KMA Interim Meeting

April 8-9, 1970

Kentucky Dam Village State Park, Gilbertsville

(More information on page 965)



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

in acute and chronic diarrheas

LOMOTIL® SAVES...

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate, 0.025 mg. (1/2,400 grain)

body fluids...
electrolytes...
patients from exhaustion

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea.

Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

gastroenteritis · acute infections · functional hypermotilit
irritable bowel · ileostomy · drug-induced diarrhea

Warnings Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy Include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:	*Total Daily Dosage*
3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. SEARLE & CO.
Research in the Service of Me

951



this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

DECEMBER

10 PANMED television series, "Almost A Miracle," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

15 PANMED television series, "Almost A Miracle," in Louisville, WKPC-TV 10 p.m.

17 PANMED television series, "Drug-Drug Interaction Affecting the Patient," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

18 Twelfth Annual Norton Seminar, "Thyroid—Parathyroid", Norton Memorial Infirmary, Louisville

19-20 Postgraduate course, Practical Ophthalmology for the Generalist, University of Kentucky Medical Center, Lexington

22 PANMED television series, "Drug-Drug Interaction Affecting the Patient," in Louisville, WKPC-TV 10 p.m.

JANUARY

7 PANMED television series, "Clinical Use of Electrical Pacemakers," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

12 PANMED television series, "Clinical Use of Electrical Pacemakers," in Louisville, WKPC-TV 10 p.m.

14 PANMED television series, "Newer Psychotherapeutic Agents: The Antidepressants," KETV-TV 10:30 p.m. EST (9:30 p.m. CST)

19 PANMED television series, "Newer Psychotherapeutic Agents: The Antidepressants," in Louisville, WKPC-TV 10 p.m.

29-31 Symposium on Modern Methods for the Medical Work-Up, University of Kentucky Medical Center, Lexington

FEBRUARY

4 Postgraduate course, "Current Concepts in Gastrointestinal and Biliary Tract Surgery," University of Kentucky Medical Center, Lexington.

MARCH

18-20 Postgraduate course, "The Head of the Child," University of Kentucky Medical Center, Lexington.

IN SURROUNDING STATES

JANUARY

2-6 Postgraduate course, "Function and Dysfunction of Gastrointestinal Tract," American College of Physicians, Bal Harbour, Florida

14-15 Postgraduate course, "Selected Problems in General Surgery and Vascular Surgery," Cleveland Clinic Educational Foundation, Cleveland

FEBRUARY

8-9 Annual Congress on Medical Education, Palmer House, Chicago

MARCH

16-18 Doctors-Nurses Joint Meeting, American College of Surgeons, Sheraton Park Hotel, Washington, D.C.

20-21 Fourth National Congress on the Socio-Economics of Health Care, Palmer House, Chicago

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their winter and spring meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in *The Journal*. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205.

The Lewis S. McMurtry Memorial Meeting of The Kentucky Medical Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 23-25, 1969

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Richard F. Greathouse, M.D., Louisville

Speaker of the House, Presiding

First Session

Speaker Greathouse ealled the 119th Meeting of the KMA House of Delegates to order and asked Paul Parks, M.D., Bowling Green, to give the invoeation. N. I. Handelman, M.D., Louisville, Chairman of the Credentials Committee, reported that a quorum was present. A motion was made, seeonded, and passed that the minutes of the 1968 session of the House of Delegates be aeeepted as published in the Deeember 1968 Journal of the Kentueky Medieal Assoeiation.

Carl Cooper, M.D., Bedford, Viee Speaker, presented the general announcements in the absenee of the Seeretary, S. R. Seheen, M.D., Louisville, who was speaking at the Orientation Course. Doetor Cooper ealled attention to the seientifie sessions beginning at 8:50 a.m. on Tuesday, September 24, at the Convention Center. He emphasized that the highlight of the meeting, the President's Luneheon, would be held on Wednesday, and feature Mr. M. Stanton Evans, Editor of *The Indianapolis News*. Doetor Cooper coneluded his announeements by reminding the delegates that the six referenee eommittees would eonvene at 2:00 p.m. Monday, in various rooms on the mezzanine floor of the Kentueky Hotel and that the Nominating Committee for general offieers would meet at the close of this first session of the House.

At this point, Doetor Seheen arrived and was reeognized to read the list of physieians who had died sinee the 1968 meeting of the House of Delegates, following which the members of the House stood for a moment of silent tribute. Given below are the names of these physieians, their locations, and dates of death:

Aker, John Raymond	Booneville	Oct. 30, 1968
Alexander, Henry T.	Frankfort	July 15, 1969
Archer, George Franklin	Louisville	April 18, 1969
Asman, Bernard	Louisville	July 24, 1969
Barton, R. D.	Louisville	Dec. 24, 1968
Barnes, Oscar Lafayette	Hopkinsville	March 19, 1969
Bird, R. Lee, Jr.	Covington	April 13, 1969
Bishop, Woodford B.	Grayson	Sept. 23, 1968
Bloch, Oscar Edgeworth, Jr.	Louisville	Dec. 23, 1968
Blue, Willis B.	Henderson	Feb. 10, 1969
Bornstein, Max	Louisville	Oct. 8, 1968
Brandon, Robert W.	Martin	April 16, 1968
Brown, William Mat	Corbin	Feb. 25, 1969
Burke, Jerome Lawrence	Cleveland, Ohio	Sept. 11, 1968
Caplan, Max	Meridian, Conn.	Dec. 6, 1968
Carlisle, Ivan Earle	Michigan Town, Ind.	
Carr, Shelby Gibson	Richmond	Sept. 20, 1968
Choate, Benjamin D.	Louisville	Jan. 26, 1969
Cole, Charles Mason	Bryan, Texas	Nov. 22, 1968
Coyle, Marcus Allen	Sptingfield	Dec. 8, 1968
Davis, Maurice S.	Frankfort	March 2, 1969
Flanary, Milton Don	Pikeville	April 12, 1969
Flexner, Motris	Louisville	June 3, 1969
Frisbie, Howard 1.	Stanford	May 2, 1969
Frizzell, William J.	Dayton, Ohio	Jan. 21, 1969
Gaither, Joseph Gant	Hopkinsville	Dec. 3, 1968
Gibson, Edwatd D.	Pompano Beach, Fla.	Dec. 22, 1968
Gregory, George Hicks	Versailles	Oct. 7, 1968
Gudenkauf, Elton Bernard	Lewisburg	Feb. 20, 1969
Hansen, Wilford Reeve	Louisville	Dec. 11, 1968
Hill, John Coburn	Louisville	Aug. 23, 1968
Howard, E. M. Jr.	Harlan	Dec. 23, 1968
Howard, Garfield	Crab Orchard	Oct. 22, 1968
Lake, Willard	Hartford	Aug. 14, 1968
Lyens, J. B.	Lawrenceburg	April 3, 1969
Mattax, James Oliver	Warren, Ohio	October 1968
Mosby, Hazel Petrie	Rockford, Ill.	Feb. 9, 1968
McChord, Charles Harrison	Lexington	Oct. 18, 1968
McCrocklin, Walter Felix	Louisville	Dec. 27, 1968
Middlestadt, Edwin Francis	Louisville	Jan. 29, 1969
Moss, Clive Arthur	Williamsburg	Sept. 16, 1968
Nagel, Louis	Louisville	Sept. 7, 1968
Pettit, Vernon David	Paducah	Feb. 3, 1969
Pierce, James O.	Beechmont	Nov. 26, 1968
Pulskamp, Marinus Henry	Louisville	May 6, 1969
Render, William E.	Louisville	Nov. 9, 1968
Rich, James Sears	Lexington	May 30, 1969
Robinson, Adam Mayfield	Louisville	May 2, 1969
Rolf, John J.	Covington	Sept. 17, 1968
Schoonover, Herbett E.	Salem, Ill.	Feb. 19, 1969
Seibert, Charles E.	Dawson Springs	April 4, 1969
Sellers, Elijah T.	Jacksonville, Fla.	Nov. 16, 1968
Shannon, Thomas A.	Lexington	March 8, 1969
Shields, Benjamin F.	Shelbyville	March 11, 1969
Shifley, Glenn M.	Paducah	Feb. 28, 1969
Silverthorn, Roy	Downey, Calif.	Dec. 7, 1968
Skaggs, Ernest Gerald	Paintsville	Nov. 15, 1968
Slone, Augustus Darwin	Paintsville	Sept. 10, 1968
Stephens, Raymond N.	Mansfield, Ohio	March 1, 1969
Stewart, Henry Van Dyke	Carrollton	
Thompson, Jamie Campbell	Outwood	March 20, 1969
Tyler, Gerald P.	California	Match 31, 1969
Tylet, William Lee	Owensboro	Jan. 3, 1969
Vidt, Charles E.	Ironton, Ohio	March 11, 1969
Von Haitinger, Kalman Scott	Grosse Isle, Mich.	July 2, 1968
Wallace, Thomas S. Sr.	Louisville	April 23, 1969
Weldon, William Adair	Glasgow	Aptil 26, 1969
Welsh, Kenneth S.	Rivetdale, N. Y.	Jan. 13, 1969
Wheeler, Owen M.	Louisville	Aug. 14, 1969
Wilber, Harold R.	DeLand, Fla	June 5, 1968
Wilhite, Everett Cook	Covington	June 4, 1969
Wolfe, William C.	Louisville	Aug. 3, 1969
Worley, Ansel Clyde	Plantation, Fla.	March 2, 1969
Wright, Earl Patrick	Pikeville	Oct. 9, 1968

**Editorial Note: A tape recording was made of the two sessions of the House of Delegates; and any member who desires to examine the transcript of these proceedings may visit the Headquarters Office and listen to the recording.*

Doctor Greathouse then announeed the Reference Committee appointments as follows:

Reference Committee No. 1

N. Lewis Bosworth, M.D., Lexington, Chairman
Harold L. Bushey, M.D., Barbourville
Burton Haley, M.D., Paducah
W. Donald Janney, M.D., Covington
Bernard Popham, M.D., Louisville

Reference Committee No. 2

Donn L. Smith, M.D., Louisville, Chairman
Max Jones, M.D., Pikeville
Glen Richards, M.D., Lewisport
Carl Scott, M.D., Lexington
Faull Trover, M.D., Madisonville

Reference Committee No. 3

James B. Cox, M.D., Hopkinsville, Chairman
Cecil Grumbles, M.D., Louisville
David A. Hull, M.D., Lexington
John S. Oldham, M.D., Owensboro
Charles B. Stacy, M.D., Pineville

Reference Committee No. 4

Edward N. Maxwell, M.D., Louisville, Chairman
Thomas L. Heavern, M.D., Highland Heights
John Hill, M.D., Somerset
Hugh Houston, M.D., Murray
Robert Houston, M.D., Eminence

Reference Committee No. 5

Paul J. Parks, M.D., Bowling Green, Chairman
Glenn W. Bryant, M.D., Louisville
John D. Fielding, Jr., M.D., Warsaw
Lowell Martin, M.D., Martin
Richard McElevin, M.D., Lexington

Reference Committee No. 6

John M. Baird, M.D., Danville, Chairman
John F. Berry, M.D., Lexington
Elbert S. Christian, M.D., Louisville
William D. Epling, M.D., Berea
John Rypstra, M.D., London

The Speaker reported that the tellers for the meeting would be Clyde Brassfield, M.D., Elizabethtown, Chairman; Raymond D. Wells, M.D., Inez, and Wallas M. Bell, M.D., Sturgis.

The physicians on the Nominating Committee were named as follows by Doctor Greathouse: Fred C. Rainey, M.D., Elizabethtown, Chairman; Paul J. Parks, M.D., Bowling Green; Joseph R. Miller, M.D., Benton; William P. VonderHaar, M.D., Louisville, and J. Sankey Williams, M.D., Nicholasville.

Reports of the offieers and eommittees were presented by the Speaker and then referred to the respeetive referenee committees as follows:

Report of the President—Reference Committee No. 1

Doctor Asman briefly summarized his report to the House. He then read the following resolution whieh he stated was adopted by the Board at its September 21 meeting:

WHEREAS, Everett H. Baker, M.D., was taken from us in Louisville on Thursday, September 18, 1969, and

WHEREAS, he had practiced medicine in Louisville for more than forty years, and was widely known and highly respected throughout Kentucky, and

WHEREAS, he had served his profession with high distinction through his County Medical Society, including holding the office of President in 1962, and

WHEREAS, he was a valued member of the Board of Trustees and participated actively on many committees of the Kentucky Medical Association, and

WHEREAS, he had faithfully served as President of the Kentucky Medical Association in 1965-66, therefore be it

RESOLVED, that the Board of Trustees of KMA deeply regrets the loss of this past president and recognizes the high contributions he made to his profession, his patients, his family, his church and this Commonwealth, and be it further

RESOLVED, that this Board express its deep and sincere sympathy to his widow and family and that a copy of this Resolution be tendered to them as further recognition of his enduring contributions to all of us.

Report of the President, Woman's Auxiliary to KMA—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker of the House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1 with the following exception: The KMA-KNA Joint Advisory Committee Report referred to Reference Committee No. 3 and the Ad Hoc Committee on Insurance Forms Report referred to Reference Committee No. 4

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

The members of the House enjoyed eoffee and sweet rolls provided by the Kentucky State Assoeiation of Medical Assistants.

Report of the Executive Secretary—Reference Committee No. 1

At this time, Doetor Greathouse announced that in keeping with a Board of Trustees reeommendation, the president of eaeh of the Student AMA Chapters had been invited to present an oral report to the House. He then ealled Mr. Jerry Lozner, Viee President of the University of Louisville Sehool of Medicine SAMA Chapter to the podium for his report. Following Mr. Lozner's presentation, the Speaker asked Mr. Paul Armstrong, President of the University of Kentucky College of Medicine Student AMA Chapter to eome forward to speak to the members of the House.

The reports of the medical students were very well received by the House, and Doetor

Greathouse commended each on his presentation.

Doctor Greathouse announced that the Chairman of the KMA Awards Committee, Richard F. Grise, M.D., Bowling Green, would now present his committee's report to the House. Doctor Grise stated that his committee's responsibility was to nominate individuals for the Distinguished Service Medal and the Outstanding General Practitioner Award. James M. Stevenson, M.D., Brooksville, was nominated for the Outstanding General Practitioner Award. A motion was made, seconded and carried to accept this nomination. Branham B. Baughman, M.D., Frankfort, was nominated for the Distinguished Service Medal, following which a motion was made, seconded, and carried to accept the nomination.

The Speaker then continued with the referrals of reports to the reference committees:

Report of the Judicial Council—Reference Committee No. 6

Report of the Rural Kentucky Medical Scholarship Fund—Reference Committee No. 6

Report of the Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 4

Report of the Scientific Program Committee—Reference Committee No. 2

Report of the Scientific Exhibits Committee—Reference Committee No. 2

Report of the Committee on Medical Education—Reference Committee No. 2

Report of the Subcommittee on Coronary Care Units—Reference Committee No. 2

Report of the Hospital Committee—Reference Committee No. 2

Report of the Educational Television Committee—Reference Committee No. 2

Report of the Disaster Medical Care Committee—Reference Committee No. 2

Report of the Cancer Coordinating Committee—Reference Committee No. 2

Report of the Advisory Committee to Blue Shield—Reference Committee No. 4

Report of the Advisory Committee to Blue Cross—Reference Committee No. 4

Report of the Committee on Occupational Health, Physical Medicine, and Rehabilitation—Reference Committee No. 3

Report of the Maternal Mortality Study Committee—Reference Committee No. 3

Report of the Advisory Committee to Selective Service—Reference Committee No. 5

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

Report of the Interim Meeting Program Committee—Reference Committee No. 6

Report of the McDowell House Board of Managers—Reference Committee No. 6

Report of the Memorials Commission—Reference Committee No. 6

Report of the Committee on Legislative Activities—Reference Committee No. 3

Report of the Committee on Communication and Health Education—Reference Committee No. 3

Report of the Committee on Health Careers—Reference Committee No. 3

Report of the Committee on Community and Rural Health—Reference Committee No. 3

Report of the Cults Committee—Reference Committee No. 3

Report of the Senior Day Committee—Reference Committee No. 4

Report of the Committee on School Health, Physical Education and Medical Aspects of Sports—Reference Committee No. 4

Report of the Advisory Committee to Woman's Auxiliary—Reference Committee No. 4

Report of the Coordinating Commission on Governmental Medical Services—Reference Committee No. 5

Report of the Technical Advisory Committee on Physician Services—Reference Committee No. 5

Report of the Advisory Committee on Title XVIII—Reference Committee No. 5

Report of the Claims Review Committee—Reference Committee No. 5

Report of the Committee on Appalachian and OEO Programs—Reference Committee No. 5

Report of the Ad Hoc Study Committee for Improved Community Health—Reference Committee No. 4

Report of the Committee on Plans and Development—Reference Committee No. 6

New Business

New business was presented to the House and referred to reference committees as indicated below:

(A) Resolution from Fayette County Medical Society relating to Sewage Systems—Reference Committee No. 3

(B) Resolution of Fayette County Medical Society pertaining to Membership of Osteopathic Physicians—Reference Committee No. 6

(C) Resolution of John F. Berry, M.D., Fayette County Medical Society, on the subject of Insured Ambulatory Diagnostic Benefits—Reference Committee No. 4

(D) Resolution of Fayette County Medical Society relating to Kentucky Physicians Mutual "A"—Reference Committee No. 4

(E) Resolution of Fayette County Medical Society on the subject of Kentucky Physicians Mutual "B"—Reference Committee No. 4

(F) Resolution of Fayette County Medical Society pertaining to Limited License—Intern—Reference Committee No. 2

(G) Resolution of Jefferson County Medical Society on the subject of Pollution—Reference Committee No. 3

(H) Resolution of Fayette County Medical Society relating to Kentucky Physicians Mutual "C"—Reference Committee No. 4

(I) Resolution from the Board of Trustees pertaining to Support for University of Louisville School of Medicine General Hospital—Reference Committee No. 2

(J) Resolution from the Board of Trustees on the subject of Famiily Practice—Reference Committee No. 2

(K) Resolution from E. B. Schoenbachler, M.D., Jefferson County Medical Society relative to Drug Combinations—FDA—Reference Committee No. 5

(L) Resolution of E. B. Schoenbachler, M.D., Jefferson County Medical Society on Usual, Customary and Reasonable Fees—Reference Committee No. 4

Vice Speaker Cooper announced the meeting places for the nominating committees for general officers and the five trustee districts electing trustees and alternates this year. Doctor Cooper said that the Nominating Com-

mittee would report immediately following the close of the first scientific session on Tuesday morning at the Convention Center, as well as at the second meeting of the House on Wednesday. In accord with the bylaws, nominations may be made from the floor on Wednesday without discussion or comment.

In making the closing announcements for this session, Doctor Cooper reminded the reference committee chairmen of their luncheon at noon today and urged the delegates to arrive on time for the opening scientific session on Tuesday morning. He also emphasized the fact that reference committee reports would be available to the House members at 4:00 p.m., Wednesday, at the entrance to the Terrace Room.

Doctor Greathouse then expressed the appreciation of the delegates for the kindness of the Medical Assistants in providing coffee and rolls during the session.

The first session of the House was adjourned at 10:15 a.m.

Second Session

Speaker Greathouse called the second session of the House of Delegates to order on September 24 at 7:10 p.m. Doctor Handelman reported that a quorum was present. Donald Chatham, M.D., Shelbyville, gave the invocation.

President Henry B. Asman, M.D., Louisville, was called to the podium, and he gave special recognition to the representatives of the surrounding state medical associations who attended KMA's annual session. They were Maynard Price, M.D., President, West Virginia State Medical Association; Robert Smith, M.D., President, Ohio State Medical Association; Carl E. Clark, M.D., First Vice President, Illinois State Medical Association; Eugene Hansbrough, M.D., Councilman, Missouri Medical Association, and Lowell Steen, M.D., President-Elect, Indiana State Medical Association.

Following these introductions, Lee C. Hess, M.D., Florence, Chairman of the Board of Trustees, was recognized to present the final report of the Board. He read the following resolution, passed by the Board at its September 24 meeting, and moved its adoption. The motion was seconded and carried:

WHEREAS, the 1969 KMA Annual Meeting has made a substantial contribution in the field of continuing medical education and has been well received, and

WHEREAS, many individuals, organizations and agencies including guests, and state essayists, scientific and technical exhibitors, newspapers, radio and television stations, hotels, and the Convention Center, have contributed to its success, therefore be it

RESOLVED, that this House of Delegates go on record as expressing its deepest appreciation to all individuals and organizations who have had a part in the development and implementation of the 1969 Annual Meeting.

The Speaker said that now the reports of the reference committees would be read.

REFERENCE COMMITTEE NO. 1*

N. Lewis Bosworth, M.D.,
Lexington, Chairman

Reference Committee No. 1 considered the following reports:

1. Report of the President
2. Report of the President, Woman's Auxiliary to KMA
3. Report of the President-Elect
4. Report of the Speaker of the House
5. Report of the Chairman, Board of Trustees (with the exception of the KMA-KNA Joint Advisory Committee and the Ad Hoc Committee on Insurance Forms)
6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the AMA Delegate
10. Report of the Executive Secretary

**In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in The Journal, the KMA Board of Trustees passed the following motion several years ago: "that if no dissenting action on the committee's recommendations is made either by the committee or the KMA Board of Trustees, only the reference committee action on the report be printed in The Journal" . . .*

Report of the President

The privilege of serving this year as President of the Kentucky Medical Association is an honor for which I will forever be grateful to you who bestowed it upon me.

It has been a gratifying year filled with hope and frustrations; and I trust, some successes. It has been a busy year due to the nature of the job but made more tiring, perhaps, by some of the unexpected developments with which all of you are familiar.

I am most appreciative of the dedication, diligence and cooperation of the trustees, the officers and the truly outstanding Headquarters staff. Without their whole-hearted backing and capable assistance, the burden of this office might truly, at times, have become overwhelming.

The committees, council and commission of the Association, too, have been most active, as you will note from their reports, and have added much to the constructive posture of our organization.

During this year, as your President, I have attended 90 meetings, 52 in Louisville and 38 out of the city. Of those requiring trips outside of Louisville, 19 involved a total of 43 days away from

home and office. Approximately 300 hours were taken up in all of the other meetings. These activities have necessitated travel of more than 13,000 miles by car and by air.

I burden you with these statistics only to emphasize a point, of which I have become more and more convinced as this year has progressed. There is no reason to believe that this year has been an unusual one in its demands upon the time and energy of your President, or that next year or the year after will find any diminution of the duties and responsibilities of the office. I need not remind you that in two out of every three years the president of the Association does not live in close proximity to the Headquarters Office, and many of those 52 meetings which I attended at a cost of a few hours would mean the loss of at least a full day to another man. The time is rapidly approaching, I fear, when KMA will find difficulty in obtaining the type of leadership it deserves to fill the office of President because of the time and economic loss it entails.

Reasoned thinking makes evident the unfairness of one man being asked to bear this burden for 2,300 KMA members. The point being made, therefore, is that wiser heads than mine in this House must develop some method to compensate their elected leader for the time and energy he devotes for the benefit of all. Some other state associations have done this for years in various ways.

This thought leads naturally to another which is closely related since it, too, involved finances. The constantly increasing activities of the Association brought on by the rapid changes in medicine have put additional strain on our budget which, as approved by the Board of Trustees for the coming fiscal year, is perilously close to the break-even point. Problems have arisen, too, in the staffing of the Headquarters Office. KMA must compete with business and industry in the Louisville area for qualified secretarial and other office personnel. All of us are aware of the wage-spiral in this category of employee in the past few years, and KMA has been caught in this same bind.

I would suggest, therefore, that this House instruct the Board of Trustees to appoint an ad hoc committee to study the present and projected financial requirements of the Association and to make recommendations next year for such changes in the dues structure that will enable it to carry on its work in an efficient and effective manner.

At the outset of my term as President, I indicated my intention to make every effort to improve communications between KMA and its members. I am most grateful, and honored, that each of the 15 trustees invited me to visit his district to meet the members and to discuss KMA with them. I was able to attend 14 District meetings, and only a critical illness in my family prevented me from visiting the Sixth District in June. During the course of these meetings, I was privileged to address approximately 15 percent of the total membership of KMA and their wives. I am most appreciative of the reception of my slide presentation and the many compliments received. I trust that those who heard it, at least, have a somewhat better working knowledge of what KMA is all about. Communications with the membership, however, continues to be a problem and demands constant and diligent efforts on the part of the leadership.

Although our rapport with the Administration in Frankfort has been markedly improved, it is quite obvious that our problems with Medicaid have not been resolved, nor are they likely to be in the near future. The program is in deep trouble, of its own making, and one would have to be an optimist to believe that Congress can amend Title XIX into an efficient, effective, fiscally sound program for the benefit of the needy.

For the next year, however, we can depend on certain lawmakers, bureaucrats and the news media to point the finger of blame at the medical profession just because a few instances of abuse and overutilization have been uncovered. We have had a few such accusations in our own state.

The leadership of KMA has made it abundantly clear to the government and to the news media that we will not be placed in a position of defending anyone who has been proven guilty of breaking the law or of violating medical ethics. By the same token, however, we are not willing to see a man convicted in the newspapers until he has been presented with the evidence against him and has had an opportunity to prove his innocence.

It has been traditional in KMA for the President to report on the activities of his term of office at this session of the House of Delegates. On the following day, during the scientific program he delivers his Presidential Address, and relying on the knowledge and experience gleaned from his year of responsibility and leadership, discusses the pertinent issues facing the Association and makes such suggestions and recommendations as, in his judgment, would be in the best interest of the physician, the profession and the public in this commonwealth.

With this arrangement; however, many members of this House of Delegates, the policy making body of the Association, have not had the opportunity to hear the words of many of our illustrious past-presidents, and I am afraid that in some instances the Association has suffered thereby.

I would suggest, therefore, that serious consideration be given in the future to a rearrangement of the program whereby the President's Address would be delivered before this House at a stated hour during the first session of the House. Since any member of the Association may attend these sessions, any interested non-delegate could be present if he so desired.

Again, I thank you for the privilege of serving as your President.

Henry B. Asman, M.D., President

Recommendations, Reference Committee No. 1

The Report of the President was reviewed with a great deal of interest and certainly with admiration for the amount of time and effort that he has expended in this arduous task. This committee feels that a wholehearted vote of thanks for a job well done is due him. The committee took particular cognizance of three paragraphs in this report which it would like to quote:

"Reasoned thinking makes evident the unfairness of one man being asked to bear this burden for 2300 KMA members. The point being made, therefore, is that wiser heads than mine in this House must develop some method to compensate their elected leader for the time and energy he devotes for the benefit of all. Some other state associations have done this for years in various ways."

"I would suggest, therefore, that this House instruct the Board of Trustees to appoint an ad hoc committee to study the present and projected financial requirements of the Association and to make recommendations next year for such changes in the dues structure that will enable it to carry on its work in an efficient and effective manner."

"I would suggest, therefore, that serious considerations be given in the future to a rearrangement of the program whereby the President's Ad-

dress would be delivered before this House at a stated hour during the first session of the House. Since any member of the Association may attend these sessions, any interested non-delegate could be present if he so desired."

The committee sincerely endorses these three paragraphs.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Motion seconded and carried)

Report of the President of the Woman's Auxiliary

Doctor's wives of the Blue Grass state are approaching the stretch of this very full program year like a Kentucky thoroughbred with a triple crown win in sight. We're proud of another annual race well run.

"Accent on Youth" describes a special priority of our 1968-69 auxiliary program which especially involved our community service, safety, and rural health committees. A stranger dropping in late for our fall state conference would have found a darkened room, colorful mod movie in progress, the smell of burning marihuana in the air, needles and yellow jackets on the table, and flowers, dolls, and the fuzz in great evidence. This pseudo-psychedelic phantasy was not a raided pot party, but a most effective information program provided by local police eager for our assistance in preventing *drug abuse* among teenagers. It provided the model and stimulus for similar local auxiliary efforts. In a related effort, our president-elect led a "write-in" campaign which saw doctors' wives from all over the state protesting to local and national executives the outpouring of *crime and violence in movie and TV* productions. A safety for children emphasis focused on the promotion of *GEMS programs* for local baby-sitter training. Eight auxiliaries sponsored GEMS efforts, with two new programs reporting 70 teenagers trained.

At the suggestion of our parent KMA, a top priority was given this year to orient auxiliary officers and members to the new national program of *Comprehensive Health Planning*. Physicians' wives were felt to have potential for effectively assisting KMA's leadership in the implementation of this effort in Kentucky. We all gave it prominence at our annual Interim Meeting, at the several district meetings, and at our county officers' workshop. Doctors' wives have now been named to important service positions on planning committees and councils at both state and area levels. Our concern for involvement in governmental affairs was furthur evidenced when nine members accompanied their husbands on this year's KMA *visit to Kentucky's congressional delegation*. The full day and evening event was a pleasant and effective means of displaying our interest to our seven representatives and two senators, all of whom were contacted.

This year the auxiliary continued emphasis on its long-standing interest in allied health manpower development. *Student loan funds* are maintained by the state auxiliary ($1,000/year) and by the majority of local auxiliaries. While these funds usually aid nursing students, several are available to other student health professionals. Most sponsor a single student, but one now is sponsoring eight! One auxiliary gained $2,000 with a Doctor's Day dance, another cleared $3,600 from a three-day Antique Fair, another had over $5,000 available—all these funds devoted to student loans and scholarships. *Health fairs* are still popular with our local auxiliaries. An especially outstanding one this year had 27 original exhibits which were seen by hundreds of young people from 65 high schools in western Kentucky. The state auxiliary this year joined a cooperative venture of Kentucky's private organizations and governmental agencies which will stimulate and coordinate *health manpower recruitment*. Known as "Health Careers in Kentucky", it will be a permanent program and has full participation of KMA and WA-KMA. Doctors' wives are now serving on its state Health Careers Council and on each district Health Careers Committee. Our auxiliary mental health interests have started a program to place a comprehensive *mental health careers notebook* in every high school library of the state, reporting 55 placements to date. At least two county auxiliaries sponsor *teenage volunteer patient aide programs* in local hospitals, and continue to report success in motivating committment to health careers.

Another interest of recent years, concerned with *mental health and mental retardation*, continues strong in the program of our auxiliaries. One county auxiliary sponsored a day at Churchill Downs for physicians' families, saw a horse race named in their honor, and raised $1,000 for a local *sheltered workshop for retarded adolescents*. Another auxiliary is starting a *day care center for retarded pre-schoolers*. Still another local unit has set up a "one-to-one" program, with members providing volunteer assistance in the supportive care of *emotionally disturbed school children* selected from needy, troubled homes. This last group also sponsors a 24 hour *telephone answering service* for local persons with emotional and behavioral problems.

Inspired leadership at state and local levels raised $4,584.23 for *AMA-ERF*. This latest count is a few dollars below last year, but would doubtless have been higher except for two unforseeable misfortunes in fund raising which resulted in significant loss of income. First, many Christmas cards sold to benefit AMA-ERF arrived too late for use; and later, the supplier of "Doctor's Wife" roses reported inability to fill numerous orders sold as donations to AMA-ERF.

As usual, many auxiliaries reported providing substantial assistance to heart, cancer, TB, and other fund drives, and help with blood collection and diabetes detection efforts. Two especially outstanding examples of such involvement in *community disease control efforts* were: (1) the 12 member auxiliary which raised $3,500 in one year by organizing a Valentine's Day Ball and by caddying the doctors' golf tournament, then donated the money for new *coronary care equipment* at the local hospital; and (2) the auxiliaries of western Kentucky whose members aided the Kidney Foundation in a special national *pilot project to detect early kidney disease* among 2,400 grade school students of their communities.

Our *international health* interests were especially high this year with our pride in a Kentuckian serving as WA-AMA international health chairman. Reported activities included making and collecting bandages, gowns, toys, soap, and drugs for distribution by HOPE, Project Concern, and World Medical Relief—many to Biafrian and Vietnamese children. A special ad hoc emphasis this year was the *International Book Project*. This program was begun 10 years ago by a Kentucky physician's wife, and now sends millions of books of all types to specific families in India. We were proud to give special attention to this people-to-people effort, and we are featuring it in a "show-and-tell" exhibit at this year's National WA-AMA Convention.

In addition to all these "outside" program activities, appropriate attention and effort have been given to the "inside" *organizational affairs* of auxiliary work. We now have 28 formally organized local groups, covering 36 counties, with memberships ranging from five to 473, and totaling 1,348 at present count (as compared to 2,300 KMA members). An additional county auxiliary is now re-

organizing, and two others plan to organize from informal local meetings of doctors' wives. This year saw the very successful trial initiation of an all-day *Workshop for County Officers* which will be continued. Our *Blue Grass News* quarterly has longer sheets, shorter type, and therefore more economy —thanks to the professional level service we receive from our volunteer member-staff. This year KMA gave permission for a fund-finding committee to seek supplement for its $1,200 budget, so we can expect even more good news per issue next year. Our *orientation program for wives* is now an established and popular adjunct to the semi-annual KMA Orientation Program required for the new members. Competition increases for our annual *Health Citation Award* with more nominations of lay individuals and organizations deserving of recognition for community health service. *McDowell House,* Kentucky's historic medical shrine, continues to grow in public popularity, due in large measure to the generous attention of one of our local auxiliaries. This year we also adopted a *new emblem,* replaced our old *pledge,* straightened out and tightened up our *by-laws* a bit more, prepared to develop uniform streamlined *reports,* celebrated SMA's *Doctors' Day* in a big way all over the state, and planned a bigger and better *convention* with maximum stimulus from its social, information, and motivational activities.

In closing, let us take no credit, but note with pride, the outstanding service projects, fund-raising activities, social functions, and informative programs of *WA-SAMA.* They have been excellent, and truly serve to provide us both challenge and encouragement for our future.

Mrs. William H. McBeath, President

Recommendations, Reference Committee No. 1

The committee reviewed the excellent report of the President, Woman's Auxiliary to KMA, and wishes to commend both the President and the Auxiliary as a body for the excellent support given our state organization. It also recognizes the excellent work that has been done outside the organization in promoting the advancement of medical interests.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried)

Report of the President-Elect

I am grateful to Kentucky physicians for honoring me as president for 1969-70. I especially want to thank President Henry Asman and the staff at KMA Headquarters for proper seasoning for the coming year. Many others in medicine have helped to afford me this opportunity. As president-elect I have attended meetings at the national and state levels. Conferences, Board meetings, and the Executive Committee were regularly attended. These activities have been reported to you more in detail by other officers and committees of the Association.

My year of learning will be most useful during this term, which confronts physicians with a challenge as never before in history. The activities of the past year lead me to believe that it is more important than ever for physicians to be concerned about not only patient care but continuing medical education, citizenship, manpower, planning, financing medical care and a whole host of other subjects. This is not the time nor place to put forth more thoughts about the coming year. Physicians must enter into discussion with insurance carriers, labor, government, and the public. The physician who does not participate and is indifferent can be responsible for the shackling of his profession. I know that during the coming year many members will be called upon to make contributions through committees and committee chairmen. My plea is that you do your jobs well for our patients and medicine. KMA's success for the coming year depends upon each of you.

Walter L. Cawood, M.D., President-Elect

Recommendations, Reference Committee No. 1

The Report of the President-Elect was reviewed and the committee wishes him a most successful term of office for the coming year.

Mr. Speaker, I move the adoption of this section of the report.

(Motion was seconded and carried)

Report of the Speaker of the House

Harvest time is here again, and we call upon the delegates to meet and help bring in the sheaves. The ideas and resolutions passed and actions taken at this Annual Meeting will represent our KMA harvest for the year. If all delegates attend and work at their job assigned, we predict that this harvest will be bountiful.

There will be no change in the parliamentary procedures governing the House this year. Reports of the committees will be presented on Monday morning, September 22, at the first session. Each report is numbered and, after presentation, will be referred to the appropriate Reference Committee. After this action, any new business or resolutions which have been submitted one week in advance of the meeting at the KMA Office will be introduced. These will be assigned a letter and referred to the Reference Committees. Reference Committees meet at 2:00 p.m. on Monday. There will be again six Reference Committees considering the various reports. They will stay in session until 3:00 p.m. or continue until everyone has been heard. Following this, they will prepare a report to present to the second session of the House of Delegates. Each delegate will have a copy of all Reference Committee reports at the second session by no later than 4:30 p.m. on Wednesday.

Any motion longer than 20-25 words must be reduced to writing, preferably typewritten, with a copy handed to the Speaker.

Please note our new format for printing the reports to the House of Delegates. Being in booklet form, the reports are easier to locate and result in a less bulky House of Delegates envelope. It is hoped that this new method will be of assistance to the Delegates.

Speaking for myself and Doctor Cooper, as Speaker and Vice Speaker respectively, it has been our pleasure to serve you during this past year.

Richard F. Greathouse, M.D., Speaker
Carl Cooper, Jr., M.D., Vice Speaker

Recommendations, Reference Committee No. 1

The Report of the Speaker of the House was considered by the committee, and we have nothing but the highest praise for the Speaker and Vice Speaker in the splendid manner in which they conduct the business of the House.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried)

Report of the Chairman, Board of Trustees

As Chairman of your Board of Trustees, I will attempt to report to you in summary form the activities of your Board during this past Associational year. The complete minutes are available in the Headquarters Office to any KMA member. As you can appreciate, much work has transpired, and the minutes are quite voluminous.

The Board has met five times during the Associational year with three additional sessions scheduled in conjunction with the Annual Meeting.

The members of the Board have expressed their dedication to the task at hand by their demonstration of performance, cooperation, and outstanding record of attendance. I wish to express my personal and deep appreciation to every member of the Board. It appears to be an insurmountable task to get away from the lengthy meetings required to handle the many problems and programs before your trustees and officers each year. It is apparent to me that this responsibility increases with each passing year.

First Meeting, September 26, 1968

S. R. Scheen, M.D., serving as temporary chairman, opened the meeting and recognized the new trustees who were as follows: C. C. Lowry, M.D., Murray, 1st District; Thornton E. Bryan, Jr., M.D., Cadiz, 3rd District; W. Bruce Hamilton, M.D., Shepherdsville, 4th District; Robert N. McLeod, M.D., Somerset, 12th District; and Paul E. Holbrook, M.D., Ashland, 13th District. Doctor Scheen then introduced the new vice president, Edwin P. Solomon, M.D., Louisville.

Walter L. Cawood, M.D., Ashland, past Board Chairman, was recognized as the new president-elect. Re-elected to positions formerly held were Richard Greathouse, M.D., Louisville, Speaker of the House; Carl Cooper, M.D., Bedford, Vice Speaker; Ballard Cassady, M.D., Pikeville, 14th District Trustee; J. Thomas Giannini, M.D., Louisville, AMA Delegate; and Charles G. Bryant, M.D., Louisville, AMA Alternate Delegate. Lee C. Hess, M.D., Florence, was elected chairman of the Board of Turstees, and George Sehlinger, M.D., Louisville, Vice Chairman.

The Executive Committee was formed when William Hall, M.D., Owensboro, and Doctor Bryan were elected to serve from the Board with the president, president-elect, chairman and vice chairman of the Board, and the secretary.

The Board then elected personnel for membership on the KMA committees for the 1968-69 Associational year.

Second Meeting, December 11, 1968

The second meeting of the KMA Board of Trustees during this Associational year was a special called meeting on Wednesday evening, December 11. The two subjects considered by the Board were Health Careers and Comprehensive Health Planning.

Mr. Tom Connelly, program director for the Health Careers in Kentucky Foundation, made a detailed explanation of this new project designed for the allied health professions to interest young Kentuckians in a health career. A thorough discussion was then held on Comprehensive Health Planning with proposals and comments being presented by Mr. Strawn Taylor, director of CHP in Kentucky, and Hoyt Gardner, M.D., Louisville, a member of the State Comprehensive Health Planning Council.

Third Meeting, December 12, 1968

The Board of Trustees then met in regular session December 12 and accepted for information the President's Report, Headquarters Office Report and reports from the senior delegate to the AMA and AMA Board of Trustees member, Robert Long, M.D., Louisville. Action was taken authorizing KMA's continuing financial participation in "Health Careers in Kentucky", approving funds for the Woman's Auxiliary membership on the state Advisory Council of Health Careers in Kentucky and naming an alternate KMA member to this same advisory council.

Nominees were confirmed for vacancies on the State Board of Health, Clinical Laboratories Advisory Board and Advisory Council for Health Facilities. Procedures for the election of the Chairman of the Board and members of the Executive Committee were approved and annual registration of physicians and Annual Meeting exhibits were discussed.

The guidelines for implementing usual and customary fee programs of all third parties through the KMA Claims Review Committee and county review committees were approved with a request that the guidelines be published in the KMA Journal and disseminated to county society secretaries. The date of KMA's Congressional Dinner in Washington, D. C., was set for May 13 and a status report of the March 26-27 Interim Meeting in Lexington was presented.

Thorough presentations were made concerning administration of the Title XIX program, activities of the Governor's Advisory Council for Medical Assistance, and implementation of the Advertising or Soliciting by Practitioners of the Healing Arts Act as specifically related to a case in Lexington involving a chiropractor. Endorsement was given to an Emergency Communications project of the Kentucky Hospital Association, the distribution of a letter to physicians relative to an eastern Kentucky ambulance attendant training program, and the naming of a KMA member to the KEMPAC Board of Directors.

A referral to the Bylaws Committee would authorize non-voting seats in the House of Delegates to a representative of the Student AMA from each of the medical schools, and a KMA sustaining membership in the Student AMA was approved. Recommendations were made concerning the TB Hospitals in Kentucky with responsibility for a more thorough study referred to KMA's Comprehensive Health Planning Committee. It was agreed that KMA would testify before state hearings on this subject.

The Chairman of the Board appointed a new Plans and Development Committee, an action approved by the Board in September. Final subjects discussed were Selective Service matters, activities of the Cults Committee, physicians on hospital boards, and the desirability of having a school health coordinator in each school district.

Fourth Meeting, March 26, 1969

The fourth meeting of the Board of Trustees was held on March 26 in conjunction with the KMA Interim Meeting in Lexington. The session opened with the presentation of routine reports. The 1969-70 fiscal year budget, presented by Budget Committee Chairman Rex Hayes, M. D., was adopted.

Actions taken at the March 12-13 Executive Committee meeting were reported for information. These included KMA's official position regarding tuberculosis in Kentucky and the status of the TB hospitals. The Board requested the establishment of a task force to plan for the eradication of tuberculosis in this state. Other items reported were KMA's position regarding the composition and duties of the State Board of Health, and approval of a special project to train clinical associates at the University of Kentucky.

James Sammons, M. D., chairman of the AMPAC Board of Directors, was then recognized for a detailed report on AMPAC's activities. Discussion was held on the recent HEW report on chiropractic as

well as the plans of the Cults Committee to disseminate this material. The Hospital Committee received approval for KMA policy on the full-time staffing of hospital emergency rooms, and action was taken on recommendations submitted by the Ad Hoc Committee on Insurance Forms to modify the procedure of completing forms demanded by "weekly" insurance policies.

Two matters received a full and lengthy discussion, one being possible conflicts between county medical society bylaws and KMA Bylaws, especially in the area of membership classifications. This problem was referred to the Constitution and Bylaws Committee for study and recommendations. Adoption of the "Usual and Customary" program by the House of Delegates in September brought forth numerous questions in its implementation. This matter was referred back to the Advisory Committee to Blue Shield for the purpose of presenting a definitive proposal for clarification.

KMA President Henry B. Asman, M.D. presented a full report on Title XIX in Kentucky to include the purpose of and progress being made in numerous recent meetings he has held with state and federal government officials. The president stated that further meetings would be held in the immediate future.

An official statement was approved noting KMA's endorsement of Comprehensive Health Planning. Motions were approved allocating $5 of each KMA member's dues as the subscription rate to the KMA Journal while the non-member rate would be $10, and authorizing legal counsel to file a brief in court relating to a decision involving the doctrine of Res Ipsa Loquitur.

It was reported that a letter had been written to the AMA supporting the candidacy of Carroll Witten, M.D., for membership on the AMA Council on Medical Service. A matter concerning Kentucky's narcotic control program was delayed pending further information.

The meeting closed with the Board accepting an invitation to hold the 1970 Interim Meeting at the new Barkley Lake Lodge on April 15-16.

Fifth Meeting, August 7, 1969

The primary purpose of the August meeting of the Board was to review the reports of all the committees. In accordance with KMA policy, Board action was taken on these reports prior to their being submitted to the House of Delegates. A number of committee chairmen were present to discuss their reports and members of the Board had been assigned specific reports for a thorough study prior to the August 7 meeting.

Routine presentations received by the Board included those of the president, secretary, senior delegate to the AMA, and the AMA Board of Trustees member, Robert C. Long, M.D., Louisville.

The report of the special committee to study tuberculosis received considerable discussion and the Board adopted a resolution expressing appreciation to George Brockman, M.D. for his outstanding service as chairman of this committee. The latest information concerning Medicaid was reported and the Board then considered the KMA position relating to the composition and duties of the State Board of Health. Disappointment was expressed that the Legislative Research Commission had distributed a report on this subject before hearings were held and it was agreed that KMA representatives would hold an additional meeting to review the LRC report prior to submitting recommendations to a hearing set for September 12 in Frankfort.

The Board: (1) selected its Judicial Council nomination for presentation to the House of Delegates, (2) confirmed KEMPAC Board appointments, (3) set September 24-26 as Annual Meeting dates for 1974, (4) agreed to meet four times during the 1969 Annual session, and, (5) approved a supplemental report presented by the Comprehensive Health Planning Committee relating primarily to the control of tuberculosis.

The members of the Board expressed pleasure in having the opportunity to approve the first multi-county medical society since the bylaws were changed last year authorizing such action. A charter is to be issued to the Pennyrile County Medical Society which is composed of the former societies of Caldwell, Christian, Muhlenberg, Todd and Trigg counties.

Upon the recommendation of the Memorials Commission, it was agreed to ask the city officials to change the name of Janet Avenue (on which the KMA building is located) to one more meaningful to medicine. Three names are being submitted for this change with the first choice being Sutton Place in memory of William Loftus Sutton, M.D., the first president of KMA.

This meeting of the Board adjourned after being in session in excess of nine hours.

In keeping with the policy of assuming more responsibility and meeting as often as is necessary to conduct the business of the Association, the Executive Committee met nine times this past year. Five of these were regular meetings, and four were for special purposes, one being a joint meeting with the Technical Advisory Committee for Physician Services (Title XIX).

The Executive Committee business transactions are reported to the Board and matters of major importance are presented to the Board with a recommendation of the Executive Committee.

The following are the reports of the ad hoc committees of the Board. The recommendations of the Board are noted on each report with the understanding that final action will be taken by the House of Delegates.

Lee C. Hess, M.D., Chairman

Recommendations, Reference Committee No. 1

The Report of the Chairman of the Board of Trustees was reviewed with the exception of the KMA-KNA Joint Advisory Committee Report, which was referred to Reference Committee No. 3, and the Ad Hoc Committee on Insurance Forms Report, which was referred to Reference Committee No. 4.

Because of the nature of this report, that is, several other reports were contained therein, our recommendations on each will be reported as follows:

Chairman, Board of Trustees

Ad Hoc Committee on Comprehensive Health Planning

Supplemental Report to the Ad Hoc Committee on Comprehensive Health Planning

Special Medicine and Religion Representative to the AMA

Chairman, Board of Trustees. This lengthy report was reviewed with the above noted exceptions. The committee could not help but be impressed with the tremendous amount of work that had confronted the Board of Trustees.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded; carried)

Ad Hoc Committee on Comprehensive Health Planning

At the organizational meeting, the committee reconciled the Trustee Districts with the Regional Comprehensive Health Planning Districts, assigning the trustee responsibility for comprehensive health

planning in each area. A compendium of the information on comprehensive health planning was assembled for the guidance of each trustee in organizational work.

The committee was assigned the responsibility for providing KMA testimony for the Legislative Research Commission hearings on tuberculosis hospitals. From this developed a meeting with representatives of all elements of the tuberculosis establishment in the state. Uniting behind KMA, all groups joined in requesting Governor Nunn to establish a "Committee for the Study of Tuberculosis," under the State Comprehensive Health Planning Council, to undertake a study in depth. This committee is now functioning.

Members of the committee participated in the establishment of Regional Comprehensive Health Planning Councils over the state. The committee has been most gratified by the dynamic assistance of the Kentucky Office of Comprehensive Health Planning under the leadership of Mr. Strawn Taylor, the director. The committee has observed with pride the very active participation of KMA members in the transactions of the State Comprehensive Health Planning Council in addition to the very diligent efforts of the many other members who have labored with the district trustees in organizing comprehensive health planning at the local level.

George F. Brockman, M.D., Chairman

Recommendations, Reference Committee No. 1

The Ad Hoc Committee on Comprehensive Health Planning report was thoroughly discussed by the committee, and we wish to commend Doctor George Brockman and his committee on the splendid work they have done.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Supplemental Report of the KMA Ad Hoc Committee on Comprehensive Health Planning

The chairman of your Comprehensive Health Planning Committee has had the unique pleasure of serving with the Comprehensive Health Planning Tuberculosis Study Committee.

This committee was initiated in the Health Facilities Task Force of the State Comprehensive Health Planning Council and was charged to make a study in depth of Kentucky's tuberculosis problem. Two physician members were nominated by the chairman of the Kentucky Tuberculosis Hospital Commission and two by the Kentucky Medical Association. In the *spiriti* of Comprehensive Health Planning, five public representatives were nominated by the Chairman of the State Comprehensive Health Planning Council.

The members are:

W. Burford Davis, M.D.	Mr. Rodney Ford
Boyce E. Jones, M.D.	Mr. Golladay LaMotte
Edward N. Maxwell, M.D.	Mr. Edward W. Lange
H. Mac Vandiviere, M.D.	Mr. Otis Wheeler

(One public member was forced to withdraw because of unexpected business pressure.)

The committee has enjoyed the strong support of all elements of the Comprehensive Health Planning mechanism, including that of Governor Nunn, whose long-standing concern about tuberculosis has led him to resist very substantial political pressures for a quick answer, in favor of an adequate appraisal.

The first finding of the Tuberculosis Study Committee was that present data on tuberculosis is inadequate. It seems axiomatic that, to plan for the future, we had best know what the present is like. Most of the work of the committee so far has been data acquisition. It is most gratifying to note the many agencies and individuals who are joining in the study. They include:

The State Board of Health and Department of Health

The Kentucky Tuberculosis Hospital Commission

The Kentucky Tuberculosis & Respiratory Disease Association

The Kentucky Thoracic Society

The Kentucky Hospital Association, which is undertaking a massive survey to determine how soon their member hospitals can begin treating tuberculosis patients.

The Department of Economic Security, which is making the first statistically-valid socio-economic appraisal of tuberculosis patient attempted in Kentucky; is preparing a codification of the Medical Assistance Program eligibility standards; and is undertaking to develop financial resource techniques for the tubercular in hospitals and clinics.

The Department of Finance, which is studying the application of Medical Assistance Program resources for the treatment of tuberculosis.

Numerous members of the Kentucky Medical Association, and other physicians, who are serving on advisory committees and in other ways giving us the benefit of their experiences.

The committee was able to get the various studies underway within two months and submit Part I of its report in which the committee proposes an orderly transition to:

"1. Return tuberculosis to the mainstream of medicine through the use of physicians, voluntary hospitals, and medical schools, coordinating the efforts of the private, voluntary and governmental agencies.
2. Develop and stimulate community participation in planning for tuberculosis control and for the treatment of tuberculosis in a community-wide comprehensive plan for health care.
3. Provide high quality ambulatory care for tuberculosis patients using expensive hospitalization only on a selective basis for clear-cut criteria.
4. Sharpen preventative activities and focus case-finding efforts toward those persons at high risk of acquiring infection and disease.
5. Consolidate the administrative and operational aspects of the tuberculosis control and treatment program."

The work of the committee has attracted wide attention in other states, as well as Kentucky. The 500-copy first edition of the report has been exhausted, and the second printing is at the press.

I cannot praise too highly the interest and zeal of the public representatives in helping to pioneer the use of the Comprehensive Health Planning mechanism in resolving some of the problems and inefficiencies of our fragmented system of health care. Hopefully, we are setting a pattern for studies of other significant problems—not with the narrow intent of saving dollars, but with a determination to develop better health service per dollar, whether the dollar comes from the public treasury, the insurance company or the pockets of the sick.

George F. Brockman, M.D., Chairman

Recommendations, Reference Committee No. 1

The Supplemental Report to the Ad Hoc Committee on Comprehensive Health Planning's report was considered and discussed in detail. The reference committee received Part I of the Report of the Comprehensive Health Planning Tuberculosis Study Committee too late for this committee's satisfactory study. We agree that tuberculosis control has long been a concern of the Association.

The committee is impressed with the potential of this broad form of survey as an approach to a rational

solution to many health problems. We would recommend that a more condensed form of the report of the Comprehensive Health Planning Tuberculosis Study Committee be supplied to the KMA members for their individual study.

Mr. Speaker, I move that this report be accepted for information and that the action recommended by the reference committee above be adopted and implemented.

(Seconded; carried)

Special Medicine and Religion Representative to the AMA

The AMA is now placing much emphasis on the role of religion and the part it plays in medicine. This has been most enthusiastically received in Kentucky.

Areas have been visited and organizations have been established or considered in such places as Owensboro, Bowling Green, Lexington, Louisville, Ashland and Covington; and there are plans to implement the work of this committee in all of the Trustee Districts.

The groundwork has been initiated by the AMA. It is recommended that we become more active in this work, as it can be a great assist in the field of medicine. The clergyman can help all of us bring courage to the discouraged.

Everett H. Baker, M.D.

Recommendations, Reference Committee No. 1

This committee considered the report of the Special Medicine and Religion Representative. The members of this committee were especially grieved at the untimely death of Doctor Everett H. Baker. We feel that this Association has lost a devoted and most effective member.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried.)

Report of the Secretary

It is difficult to believe that another year has passed since our last Annual Meeting. During the past year there have been a number of new challenges to face in medicine, and most of these have been concerned with the interest of the KMA in the implementation of the various governmental insurance programs, as well as helping to advise the private insurance carriers. It is my impression, as secretary and having sat through numerous meetings during the past year, that these have been the major problems which have confronted the Association during this time.

The utilization of these programs has become quite complicated both from the administrative standpoint as well as from the usage by the patient. KMA has endeavored through long and arduous work by members of the various committees to aid in any way possible. It seems to me that during these times, it is more important than ever for the individual physician to know his trustees in the district, as well as the delegates, and to communicate through them any problems or desires which they may wish to come before the KMA Board.

You gentlemen are the elected delegates from your particular areas. As you know, it is your job to attend meetings and to report back to your particular county society regarding action of the House of Delegates. You are the main line of communication between the KMA and your county societies. Do not let this line of communication break. All physicians in the society will be aware of the work which is being done by the KMA for them if you will follow this through.

I would like to give you some information regarding the number of meetings in which the Association has been involved in the past year. The total number of KMA committee meetings was 48, lasting a total number of 120 hours, at which 275 members were in attendance. The total number of doctors' hours involved was 737 and total number of doctors' miles traveled was 37,410. The KMA Board of Trustees met six times for a total number of 25 hours. There were 147 members in attendance and a total number of doctors' hours involved were 747. The total number of doctors' miles traveled was 22,420. The Executive Committee met on eight occasions for a total number of 42 hours. The total number of members was 302 and total number of doctors' miles traveled was 10,972.

I would like at this time to thank all of those who have helped me during the year with my particular job. I would also like certainly to commend all of our staff at the Kentucky Medical Association for their dedication to their jobs, and the fine way in which they have carried out all of their duties and functions. We are very fortunate to have such a fine staff, and they certainly reflect our interest in the continuation of good medical practice throughout the state of Kentucky.

S. Randolph Scheen, M.D., Secretary

Recommendations, Reference Committee No. 1

The Report of the Secretary was reviewed, and the committee wishes to congratulate the Secretary on a job well done.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried.)

Report of the Editor

During this past year the cover of The Journal was changed to some extent in that we changed to a blue color—and we changed the masthead to emphasize the word "Kentucky."

Another change which was initiated during the past year was a new feature called "Medical Progress"—which will appear on a bimonthly basis. We have been fortunate during the year in receiving a steady supply of good scientific papers. We thank those who have submitted these to The Journal for publication, and we want to take this opportunity to urge other Kentucky physicians to submit similar papers for The Journal.

The Journal serves several functions for Kentucky physicians: It continues to be an instrument for post-graduate medical education. It serves as a historical document for Kentucky medicine. Another of its functions is to keep Kentucky physicians informed concerning contemporary medical events. The Journal has a post-graduate page and attempts to list all known medical meetings well in advance. The Journal cannot only help to promote these meetings—but can act as a clearing house to avoid conflicts in meeting dates.

The editors take this opportunity to express their appreciation to the pharmaceutical companies who advertise in The Journal. At the present time there is apparently a national trend for the pharmaceutical companies to spend more on national advertising and less on state advertising.

The editors meet regularly regarding the affairs of The Journal, and would welcome any suggestions

from any of the members of the Medical Association at any time. These suggestions can be either written or called in—to the editor's office of KMA.

Walter S. Coe, M.D., Editor

Recommendations, Reference Committee No. 1

The Report of the Editor was reviewed. The editor and his staff are to be complimented on the manner in which they have performed their duties in publishing the Journal of KMA.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the KMA Treasurer

You will find enclosed in your House of Delegates envelope a Statement of Financial Condition of the Kentucky Medical Association as of June 30, 1969, a Statement of the Changes in the Fund Balances, and Condensed Statements of Income and Expense of the Current Fund, Reserve Fund, McDowell House and the Postgraduate Medical Education Fund for the year ending June 30, 1969.

The complete report of audit for the fiscal year ending June 30, 1969, is available to all members of the Kentucky Medical Association at the KMA Headquarters Office, 3532 Janet Avenue, Louisville, Kentucky.

Keith P. Smith, M.D., Treasurer

Recommendations, Reference Committee No. 1

The Report of the Treasurer was reviewed, and this committee recommends that:

(1) The Board of Trustees consider the feasibility of coordinating the fiscal year to coincide with the Associational year.

(2) That in the future the attachment to this report (the Audit Report) be stated in terms that can be clearly understood by the membership.

We wish to thank Doctor Smith for his interest and work.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded; carried)

Report of the Delegates to AMA

This past year your delegates and alternate delegates, as well as KMA officials and other interested members, have been in attendance at the clinical session at Miami Beach in December and the Annual Meeting in New York in July, 1969; and all have been active participants in the business of organized medicine, that is county, state and national levels.

Steerage, not breaks, has been the policy of the President, Dwight Wilbur, M.D. this past year; and the changes which are beginning to be seen, at least at the AMA level, have been a direct result of this theme. Doctor Wilbur stated that, in all probability, one of our greatest problems in American medicine has been that we have tried too hard and succeeded too well in the health care of the country and that now many people are impatient regarding the health care problems of the country, in that they wish to instantly wipe away poverty, eliminate ignorance, sweep away all ill will and violence and replace jealousies and hate with universal good will.

Many items pertaining to changes of the national policy were brought up and finalized at this meeting and concluded in a policy on discrimination with a provision for disciplinary action if repeated evidences of violations were in evidence.

The House also, at the recommendation of the Board of Trustees, accepted an objective assimilating qualified osteopaths to the main stream of American medicine and suggested a broad methodology by which these objectives might be accomplished over a period of time in order to improve the caliber of medical care under their supervision. The House also suggested methods by which state and county medical societies may accept qualified osteopaths as active members, and by accomplishing this, permit them to become members of the American Medical Association.

ORGAN TRANSPLANTATION — The House adopted statements on heart transplantations which makes five points: 1) The preservation of good medical practice demands that the evolution therapy be orderly. 2) Due regard for the welfare and safety of each individual patient is paramount. 3) Heart transplants have brought about medical, ethical, and legal questions into critical focus, including the determination of death. 4) Potential heart transplantations may prove by subsequent clinical experience to be severely limited by the shortage of potential organ donors. 5) Heart transplantation has been accompanied by the onset of a degree of public awareness and almost without parallel to medicine. It is, therefore, imperative that the public be made fully aware of the potentialities and limitation of heart transplant.

HEALTH CARE COSTS AND FINANCING— The House again, following similar action at the 1968 annual convention, accepted for information the report of the committee of the health care financing, pertaining to federal income tax credits for the person's health insurance and adopted a resolution that the AMA seek to promote enactment of federal legislation which would translate the concept of income tax credits for health insurance premiums into law. The House, in addition, asked the Board of Trustees to obtain sufficient staff, facility, and funds to develop an effective program for immediate and ongoing studies on health care costs and to report at the 1969 annual convention.

In other action regarding health care, the House called on all voluntary health insurance organizations to offer reinstatement to all contracts which were cancelled or converted because of Medicare and reaffirm to AMA's belief that the concept of voluntary health insurance is the most acceptable means of financing care.

MATTERS OF PATIENT PUBLIC INTEREST— The House adopted a council on medical education special requirements for residents in training and family practice. It was resolved that the AMA affirm the importance of providing appropriate recognition for family physicians by means of a primary specialty board.

The House endorsed a principle of multi-purpose health record forms. Multiple other items regarding allied health personnel, questions of medicine in government, and policies pertaining to AMA were reaffirmed and multiple programs were considered. It was recommended that the AMA use every effort to suggest to the government that all overlapping medical programs with Medicaid be phased out by using our AMA influence as best as possible in this regard.

Re-definition of usual and customary fees were reaffirmed by the House. Also, the question of direct billing was reaffirmed.

At the AMA Annual Meeting in New York many significant policies were adopted. The House accepted the report of *Management Study of AMA* by Cresap, McComick & Paget together with Board comments. The House assigned "highest priorities"

to these areas of activity: 1) Rising cost of health care, 2) Expansion of out-of-hospital health services, 3) Development of community health centers, 4) Experimentation and innovation on new methods of delivery of health services, 5) Medical audit, utilization and review committees, 6) Medical manpower needs, 7) Preventive medicine, and 8) Family planning.

The House adopted a revision of bylaws to provide increased cooperation between *specialty societies* and AMA. Changes establish a council representing the specialty for each AMA scientific section, with membership of section councils to be selected from among AMA active members by the national specialty societies listed in the American Medical Directory, based on the number of AMA members in the specialty society, and one member elected by the section.

The House adopted the Board's report of the Committee on Health Care of the Poor *calling for action programs* to meet *already documented needs.* It also adopted a *resolution reaffirming* its position: "(1) that it is a basic right of every citizen to have available to him adequate health care, (2) that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care, and (3) that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

Adopted a report on the Council on Medical Services program to *stimulate peer review,* called attention to Board's statement *"that peer review be assigned the highest priority"* by medical societies, and urged representative attendance at the Council on Medical Services conference on peer review November 29 in Denver.

Adopted a Council on Medical Services report outlining AMA support of broad voluntary health insurance programs and urging medical societies and individual physicians to promote and publicize AMA's graduated income tax credit program.

The House approved Board report calling for increased federal financial support of medical schools to permit larger enrollment. This changes AMA policy regarding federal loans to medical students, made necessary by high interest rates on loans from private sector.

Adopted bylaw amendment enabling *qualified osteopaths* to become active members of AMA through membership in state medical associations.

Again, I wish to thank all the other delegates, alternate delegates, and state officials who helped me with this.

J. Thomas Giannini, M.D., Delegate to AMA

Recommendations, Reference Committee No. 1

The Report of the AMA Delegate was discussed thoroughly in our session and the section on Health Care Costs and Financing was particularly discussed and strongly supported. Further, this committee would go on record as being strongly opposed to any form of national health insurance on the basis of (1) its compulsory nature; (2) fixed fees; (3) pre-payment panel group participation only; and (4) limitation of free choice of physician on the basis of (3) above.

The committee wishes to congratulate all of the delegates on their interest and excellent performance.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded; carried)

Report of the Executive Secretary

This Annual Meeting completes the first full Associational year that I have served as your Executive Secretary. It has been a challenging and gratifying experience.

I shall not report in detail concerning the responsibilities of the Headquarters Office as the ever-increasing work load and vortex of activity evolving around your staff are reflected in the numerous reports of your officers and committee chairmen.

On an average day various staff members are attending committee meetings, editing promotional material, representing KMA with allied and other organizations, duplicating minutes, getting out a mailing, working on the Journal, answering routine phone calls (three lines busy constantly), scanning stacks of mail and responding as may be indicated, greeting visitors, researching material for a future committee meeting, discussing projects with officers, making plans for state-wide meetings of our own and in conjunction with other groups, attempting to keep pace in the area of public and governmental relations, and trying to maintain our own continuing education by reading some of the voluminous material received daily relating to projects and programs of organized medicine throughout the nation. The interesting aspect, however, is that there is no "average" day, as each one seems to bring something new and unexpected.

As governmental medical programs have an increasing affect on the physician's office, so too does it demand ever increasing amounts of staff time. The "Medicaid burden" alone has seemed to have been a daily agenda item.

The House of Delegates last year requested KMA to maintain two staff men in Frankfort during the Kentucky General Assembly. We were pleased to welcome Mr. Jerry Mahoney to our staff in March. His experience will prove valuable to us as he assists Mr. Armstrong in Frankfort for the next session of the Legislature beginning in January. A portion of Mr. Mahoney's many duties has been making field service visitations, and most of our 120 counties have received personal visits during this year.

During the past 12 months, there have been some 165 KMA meetings that have involved staff activity and attendance. In addition, staff has represented KMA at 125 other meetings of related interest and spent approximately 50 "staff days" representing the Association at out-of-state meetings.

To meet the short term and long range challenges facing us, innovations must be an ever present duty in the administration of any organization. Responsibilities within staff are being consistently reviewed to try and assure maximum effectiveness.

One of my most rewarding experiences has been to work more closely than ever before with the officers, committee chairmen, and other members of KMA. My deep appreciation is extended to all of them with a special word of thanks to KMA president, Henry B. Asman, M.D., who gave so unselfishly of his time to staff and me personally during this first year. The understanding, counsel, and overall supervision of the Headquarters Office by the entire official family of KMA has been received with deep gratitude.

Words could not express my feeling for our courteous and efficient staff who continually give that extra effort in performing with sincere dedication for the interest of this Association.

Robert G. Cox, Executive Secretary

Recommendations, Reference Committee No. 1

The Report of the Executive Secretary was considered by the committee, and enough could not be said in praise of our Executive Secretary and his faithful staff in their loyal performance of their duties for this Association.

Mr. Speaker, I move the adoption of this section of the report.

(Second and carried)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1 as a whole.

(Seconded and carried)

Mr. Speaker, as chairman, I wish to thank all of the members of this committee for their untiring efforts and help in preparing this report.

I also wish to thank Mrs. Sandra Murphy for her excellent help.

REFERENCE COMMITTEE NO. 1
N. Lewis Bosworth, M.D., Lexington, Chairman
Harold L. Bushey, M.D., Barbourville
Burton Haley, M.D., Paducah
W. Donald Janney, M.D., Covington
Bernard Popham, M.D., Louisville

REFERENCE COMMITTEE NO. 2

Donn L. Smith, M.D., Louisville, Chairman

Reference Committee No. 2 considered the following reports:

14. Report of the Scientific Program Committee
15. Report of the Scientific Exhibits Committee
16. Report of the Committee on Medical Education
17. Report of the Subcommittee on Coronary Care Units
18. Report of the Hospital Committee
19. Report of the Committee on Educational Television
20. Report of the Disaster Medical Care Committee
21. Report of the Cancer Coordinating Commitee

Resolution F—Limited License—Intern (Fayette County)

Resolution I—Support for University of Louisville School of Medicine General Hospital (Board of Trustees)

Resolution J—Family Practice (Board of Trustees)

Report of the Scientific Program Committee

The Scientific Program Committee met November 6, 1968, to outline plans for the 1969 scientific session. As you will note from that date, nearly a full year's preparation goes into the presentation of your scientific program for each year's Annual Meeting. Your chairman, committee members, and the KMA staff are involved in countless telephone calls, personal contacts and reams of correspondence in putting this program together.

From past experience, it has appeared that the selection of themes for portions of the scientific program has proven to be beneficial, and that policy is being carried over into this year's session. The themes are designed to assist in the continuity of the program and afford an opportunity for in-depth coverage of a subject. We hope you again find them to be profitable.

The scientific programs of the specialty groups held in conjunction with our general sessions have proven over the years to be valuable to all concerned, and makes for an outstanding contribution of continuing education to our members. I have had the pleasure of meeting with the specialty group presidents in planning this year's meeting, and I am grateful for their approval of the facilities offered for their meetings and for their cooperation in the planning of the overall program.

The Message Center in the Technical Exhibit Hall has proven its value to our members attending the meeting, and we are again most appreciative to the South Central Bell Telephone Company for its support in sponsoring the Message Center.

In preparing for each year's scientific session, your committee reviews previous programs in an attempt to select the best format of each. Your committee members strive to present an appealing and educational program that will provide maximum benefit to the individual physician.

This year, we are attempting a blend of panel presentations and individual papers along with the innovation of a new "crackerbarrel" session which will permit informal round table discussions on Wednesday afternoon.

Your chairman is grateful to all of those who assisted in the formation of this program with a special note of appreciation to the committee members, specialty group presidents, and program chairmen and panel moderators. The help of the Executive Staff of the KMA makes the work of the chairman a pleasure. They should be commended for their efforts.

Any suggestions our membership may have for future programs are most welcome.

Peter P. Bosomworth, M.D., Chairman

Recommendations, Reference Committee No. 2

We have studied the Report of the Scientific Program Committee and recognize that a great deal of effective work has been achieved in the preparation of this year's scientific program. We compliment the committee on the excellent program that has been arranged for this year's meeting.

We would also like to express on behalf of the Kentucky Medical Association our appreciation to the South Central Bell Telephone Company for their continued sponsorship of the Message Center.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Scientific Exhibits Committee

Since it is necessary for our committee to meet late in the summer to review all applications for presenting scientific exhibits at the Annual Meeting, it has become policy for our submitting a final report in advance of our meeting so that it may be processed and distributed with the other committee reports.

Our meeting is being held this year on July 17, at which time we will carefully review all applications submitted to us and make selections of those to be presented.

We anticipate having approximately twenty scientific exhibits for the 1969 meeting. They are to be in place in the Convention Center by 8:00 a.m., on Tuesday, September 23, and will not be removed until 3:30 p.m., on Thursday, September 25.

Our policy of judging the exhibits is being continued, and the judging team will select the most outstanding exhibits with the first place award recipient being recognized during the General Sessions at 11:30 a.m., on Wednesday morning. We would like to see more of our members present exhibits, and we urge your consideration of planning toward such a project for next year's meeting.

Special badges and ribbons are used to identify our Scientific Exhibitors, and they are eager to discuss their exhibit with you. A certificate will be awarded each exhibitor in appreciation of his interest in this phase of continuing medical education.

Our committee members desire to take this opportunity to urge all members attending the Annual Meeting to visit the exhibits which will be located

in the Convention Center between the technical exhibit hall and the General Sessions.

T. R. Marshall, M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Scientific Exhibits Committee was read with interest, and the reference committee extends its appreciation to the committee and to the exhibitors for their cooperation in making the program a success.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Committee on Medical Education

The Medical Education Committee was quite active during the 1968-69 Associational year. While only two meetings were held, the groundwork between meetings by the members was extensive.

One of the charges to the committee is to study and make recommendations on matters relating to PL 89-239 (Heart, Cancer and Stroke). The first operational funds have been granted to the Ohio Valley Regional Medical Program in the amount of $935,000, and the focus of this grant is the continuing education of physicians in Heart, Cancer and Stroke. A second grant has been applied for and is under consideration at this time, and when funded, will extend the scope of the first grant.

Consideration is now being given to subsequent grants to be used in the area of developing and effectively utilizing medical manpower, specifically that manpower concerned with ambulatory (non-institutionalized) patient care.

Your committee is also concerned with the American Medical Association Education and Research Foundation, and cooperated with the American Medical Association in a joint appeal for funds which will be used in Kentucky's two medical schools.

Another project of the committee members was to study the feasibility of establishing a continuing medical education film library using a moviepak film format. A poll, to determine interest in this project, was taken of a number of physicians across the state, and the response was favorable. However, upon further examination of all factors, the committee felt it best to wait until some of the operational problems are worked out before committing any finances from the KMA Post Graduate Education Fund to this project. Further consideration will be given to this program next year.

In an attempt to bring about a closer liaison with the students of both medical schools, the committee recommended that reports from the SAMA presidents of each school be given directly to the KMA House of Delegates. The KMA Board of Trustees approved this recommendation, and the House will be asked to vote on the necessary bylaws change at their second meeting on Wednesday evening.

As in the past, two members of this Association were asked to be representatives to SAMA so there would be proper representation at the Commonwealth's two medical schools. Hoyt D. Gardner, M.D., was asked to be the representative to the University of Louisville, and Donald E. Edger, M.D., was asked to be the representative to the University of Kentucky. Their individual reports will follow as an addendum to this report.

Another major area of discussion by the committee concerned the best available means of continuing the education of today's busy practicing physicians. As a result, the suggestions were made to the editors of the *KMA Journal* to publish short, informational reports on scientific subjects, similar to those published in the *New England Journal*. This recommendation was approved by the editors, and the reports, as described above, began appearing in the June issue of the *KMA Journal*.

Recipients of the KMA Faculty Scientific Achievement Awards were selected.

The KMA Biennial Conference on Medical Education was discussed; the next conference will be held in January, 1971.

I, as Chairman, would like to thank the members of the committee: Charles F. Blankenship, M.D., Ralph M. Denham, M.D., William S. Jordan, Jr., M.D., Elmer G. Prewitt, M.D., Carl H. Scott, M.D., and Donn L. Smith, M.D., for their efforts and cooperation during this Associational year.

Walter I. Hume, Jr., M.D., Chairman

SAMA Representative to the University of Kentucky College of Medicine

I have had several interesting, informative and fruitful contacts with the president of the Student AMA Chapter at the University of Kentucky. In these days of student riots, etc., the U.K. medical students are restless, uneasy and concerned, but not rioting. They have a great desire and need for contact with the private sector of medicine. To this end, Fayette County Medical Society, this year, has been inviting three students to each monthly dinner meeting. The students have accepted these invitations with enthusiasm and have gained some further insight into the workings of organized medicine.

The FCMS meetings and the KMA Senior Day Program only provide a small part of the need for dialogue between student and practitioner. Hopefully, this need can be further met in the future by the addition of preceptorships, discussion groups and externships.

Donald E. Edger, M.D.
KMA Representative to SAMA
University of Kentucky

SAMA Representative to the University of Louisville School of Medicine

The general conduct of business for the University of Louisville Chapter has been a most interesting year. They served as host for the regional meeting involving 11 other states which was held at Stouffer's Inn in February, with a successful turnout and an interesting agenda. This has been a year of student activism in AMA, and the restructuring of both the administrative staffing and the general projects of the House of Delegates and the Board of Trustees has been one of vigorous undertaking. They have extended areas of interest into neighborhood health centers, the inner city and wide-ranging concerns such as medical school curriculum, and also the inclusion of interns and residents under the Student AMA structure.

Our delegates, both from the University of Louisville and the University of Kentucky, attended the annual meeting of SAMA in Chicago at the Hilton Hotel in March, and one of our freshman students from the University of Louisville, William Moss, was elected district director. This seems to be following in the footsteps of his brother, James Moss, who is a past president of Student AMA.

With the new student activism taking place, it has caused a considerable amount of study, both by AMA and many of the state societies; but at this point, it is felt that the general considerations that SAMA has undertaken are new approaches, but do not show any incompatibilities at this time with the general

organizational facets of AMA protocol. For the neighborhood health center at Kansas City, Kansas, AMA has extended again an annual contribution of $38,000.00.

At the Annual Meeting, a junior student from the University of Kansas, Ed Martin, was elected president.

Since these are the coming generations of medicine, every physician is encouraged to give his help, advice and attention to both the University of Louisville and University of Kentucky Chapters in order that we may give our experience and information to them to be utilized in a fashion that they will see fit, and also, that they may draw what knowledge from this kind of assistance that they may find helpful.

There has been a great concern throughout the country regarding revolutions on the campus, but it can be said that while our medical students are seemingly considerably more aggressive in many areas, and obviously much more outspoken, they are still considerably more appropriate to the general approaches to health care and general good citizenship, than has been, apparently, the general theme on campuses across the country. The fact that a professional person in his early, formative years finds reasons and cause to offer new solutions to old problems, or to present new avenues hitherto unexplored, should not necessarily automatically result in condemnation to him or in retribution against him until all the information that he submits has had suitable analysis. Conversely, the strength of the practice of medicine should be closely scrutinized by our new and next generation of physicians so that they may see that the sinews of strength have been broad, intelligently arrived at and, by far, the majority supported. It is hoped that the challenges of next year will be as interesting and stimulating as those of the past.

Hoyt D. Gardner, M.D.
KMA Representative to SAMA
University of Louisville

Recommendations, Reference Committee No. 2

The Report of the Committee on Medical Education was reviewed with care and interest. We note with appreciation the report of the Kentucky Medical Association's representative to SAMA at each of the two institutions. It is the hope of the committee that it will become feasible to establish a continuing medical education film library. The reference committee also notes that the reports of the SAMA presidents for each school may be given directly to the House of Delegates without changes in the bylaws.

We are grateful to the Committee on Medical Education for its excellent report which we accept as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded and carried)

Report of the Subcommittee on Coronary Care Units

The Coronary Care Units Subcommittee was organized two years ago at the request of representatives of the Kentucky Nurses Association through the KMA-KNA Joint Advisory Committee.

No specific requests have been made of the committee this year, consequently no meetings were held.

Henry W. Post, M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Committee on Coronary Care Units was reviewed and accepted as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Hospital Committee

The members of the Hospital Committee have met twice this Associational year, on December 19, 1968, and again on March 20, 1969.

The full-time staffing of hospital emergency rooms has increased this year with a number of hospitals initiating activity in this area and with considerable diversification in their approach to emergency room coverage. It became apparent that guidelines for staffing emergency rooms were essential for the hospitals, physicians and third parties concerned. The committee members studied this matter in detail and invited representatives of other affected groups to meet with us. We requested and receivd from the KMA Judicial Council a ruling on the ethical principles involved.

Our recommendations on this subject were approved by the KMA Board of Trustees on March 26, and were subsequently disseminated to all hospital chiefs of staff, county society secretaries and the Kentucky Hospital Association as KMA policy on the fulltime staffing of hospital emergency rooms.

Our "Dry Run" Hospital Accreditation Team visits have continued to be available to the hospitals in the state. As the passage of Medicare increased our activity in this area, we made additions to the number of individuals available to our teams, and wish to express our appreciation to these individuals for their time and effort. The "Dry Run" program is under the joint sponsorship of KMA, the Kentucky Hospital Association and the Kentucky Association of Medical Record Librarians. Since the inception of this program in 1962, twenty-five dry runs have been made upon request by Kentucky hospitals. In addition to "Dry Run" visits, we have met with representatives of hospital staffs and hospital Boards of Trustees to assist in seeking solutions to problems confronting the efficient operation of hospitals.

Your Chairman had the honor of representing KMA at the February 10-11 meeting of the Joint Commission on Revision of Standards for Hospital Accreditation in Chicago. The Kentucky Hospital Association is to be complimented for their broad-minded participation in this conference, and we in KMA enjoy a fine working relationship with KHA.

For the past two years, the Department of Health, as a result of Medicaid and Medicare, increased their activity in the inspection of hospitals to attempt the enforcement of hospital licensure regulations. Our committee spent a great deal of time discussing this matter, some of the current problems, and the inspection methods that should be utilized. Our concern resulted in a number of recommendations being made to the KMA Board of Trustees concerning the State Health Department inspection teams, their method of operation, the cooperation and coordination of KMA and KHA and other policies concerning their inspections. The KMA Executive Committee has studied these recommendations and our committee is currently trying to determine a feasible means of implementing them.

Other matters discussed by the committee were the TB Hospital situation in Kentucky, Comprehensive Health Planning and the progress of the Regional Medical Programs in Kentucky.

We strive to maintain liaison at both the national and local levels, and through the cooperative effort of allied groups, to be of maximum service to you.

James B. Holloway, Jr., M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Hospital Committee was reviewed and considered. The reference committee extends to the Hospital Committee our appreciation for its able report of what appears to be a busy and productive year. The committee notes with appreciation and interest the Hospital Committee's work in the area of emergency room staffing. The efforts of the Hospital Committee in the fields of hospital accreditation and comprehensive health planning are recognized with appreciation. We accept the report as written.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded: carried)

Report of the Committee on Educational Television

The KMA's Educational Television Committee has met and is continuing to meet during the year in hopes that we can go on the state educational network with several short programs in the very near future.

Our plans call for two long programs on cancer subjects before the year is out. These would probably be 30 to 45 or 50 minutes in length.

The KMA-ETV Committee has been funded with a pilot study grant by the Kentucky Cancer Society, to put on the educational television network, two programs concerned with cancer and its associated complications and treatments.

At this time two programs have been approved by the committee and are in the process of being scheduled for showing over the ETV Network in September. The first program will be on "Cancer" and the second will be on "Sports Medicine."

Excerpts from both programs have been incorporated into a slide presentation which is on display in the Scientific Exhibits area at Convention Center.

William P. VonderHaar, M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Educational Television Committee was read and discussed. The reference committee hopes that the programs to be produced by the Educational Television Committee will become known to the physicians of the state by appropriate notification and communication. The reference committee commends the committee for its efforts in the area of education and accepts its report as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Disaster Medical Care Committee

The Disaster Medical Care Committee met on only one occasion this year, but the committee was active in continuation of previous projects and the development of new projects.

Time was spent with the Kentucky Hospital Association Committee in the investigation and development of an emergency hospital communications system.

In conjunction with the Kentucky Highway Department and the Kentucky Hospital Association, signs were placed along the interstate system indicating hospitals with effective emergency medical service.

The Kentucky Medical Association Disaster Medical Care Committee has been working on a demonstration project for the training of ambulance attendants for southeastern Kentucky. Members of the Association will serve on the faculty.

Attention of the Association was directed to a movie, much of which was made in Kentucky by the American College of Surgeons on emergency ambulance service, organization and operation.

A meeting was jointly sponsored by the KMA and the Kentucky Hospital Association on hospital emergency planning and civil disorders.

In addition to the above, the Disaster Medical Care Committee continues its interest in Medical Self-Help Training and as of April 30, 1969, a total of 267,898 Kentuckians had completed Medical Self-Help Training in more than 9,000 courses. This training is designed to assist individuals in an emergency situation in caring for themselves until medical aid can be rendered.

The committee also maintains liaison with the Public Health Service and the Division of Health Mobilization and they have advised us that contracts have been negotiated with 40 hospitals in Kentucky for affiliation with a 200 bed Package Disaster Hospital or participation in the Hospital Reserve Disaster Inventory Programs or both.

At the present time, according to the Public Health Service, the Kentucky emergency medical stock pile consists of 190,000 patient care days in the PDH Program and 102,000 patient days of supplies in the HRDI Program.

William T. Rumage, Jr., M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Committee on Disaster Medical Care was reviewed. The reference committee was impressed by the large number of Kentuckians who have completed medical self-help training in the many courses offered. The members of the reference committee express the hope that the Disaster Medical Care Committee will report in the future on the feasibility of setting requirements for ambulance attendants throughout the state. The reference committee compliments this committee on its very active and effective program in disaster medicine.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Cancer Coordinating Committee

You may recall that last year, the Cancer Coordinating Committee directed its efforts in the area of the coordination of cancer follow-up and reporting in the fourteen approved Kentucky hospital cancer registries and the State Cancer Registry.

The committee has not found it necessary to meet during this Associational year; however, we anticipate more activity during the next year.

Condict Moore, M.D., Chairman

Recommendations, Reference Committee No. 2

The Report of the Cancer Coordinating Committee was read and accepted as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Resolution F

Fayette County Medical Society

WHEREAS, interns at one time were licensed in the State of Kentucky and are not now currently licensed; and

WHEREAS, by granting a limited license to interns graduated from qualified American or Canadian medical schools would considerably simplify the patient record keeping and patient prescription problems created by lack of such license; be it

RESOLVED, that interns in the State of Kentucky, at the time of their appointment, be granted a limited license in accordance with the following revision of the licensing laws applicable to physicians in the State of Kentucky.

"The limited license shall entitle the licensee to perform duties of an Intern in a hospital located in the Commonwealth of Kentucky and authorize the licensee to sign birth and death certificates, orders for narcotics, barbiturates and other prescription drugs provided the execution of same involves duties within the scope of the limited license. The 'Limited License—Intern' shall terminate at the end of one year, not be eligible for renewal and shall have no effect upon any subsequent licensure to practice medicine which may or may not be granted in the future.

"It is recommended that the attorney for the Kentucky Medical Association be directed to consult with the State Board of Health to determine the most appropriate method to achieve a limited licensure for interns. It may be more desirable to seek a change in the Medical and Osteopathic Regulations rather than to amend the Medical and Osteopathic Practice Laws (KRS 311.500 — 311.990). It is further suggested that appropriate documents be drawn and action pursued to achieve the appropriate and necessary legal actions."

Recommendations, Reference Committee No. 2

Resolution F, concerning Limited License for Interns, introduced by the Fayette County Medical Society, was read and discussed at length. Reference Committee No. 2 recommends the adoption of this resolution as written.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Resolution I

KMA Board of Trustees

WHEREAS, the Louisville General Hospital has served long and well as the primary training hospital of the University of Louisville School of Medicine helping train many of Kentucky's physicians now located throughout the Commonwealth, and

WHEREAS, the inadequate and aging physical state of the present Louisville General Hospital is a matter of public record, and

WHEREAS, an effective, modern teaching hospital is vital and necessary in the training of those future physicians who will enroll in the University of Louisville's new and enlarged Medical School, therefore be it

RESOLVED, that the House of Delegates of the KMA encourage the building of a new Louisville General Hospital to be the primary teaching hospital of the University of Louisville School of Medicine.

Recommendations, Reference Committee No. 2

Resolution I, Support for University of Louisville School of Medicine General Hospital, introduced by the KMA Board of Trustees, was reviewed and considered. The reference committee recommends the adoption of this resolution as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Resolution J

KMA Board of Trustees

WHEREAS, a certifying Board in Family Practice is now a reality, and

WHEREAS, there is a dire need throughout the Commonwealth of Kentucky for more physicians in Family Practice, and

WHEREAS, establishing new departments of Family Practice in our medical schools obviously needs financing, therefore be it

RESOLVED that the KMA endorse the establishment and funding of educational programs adequate to meet the requirements of the new Board of Family Practice.

Recommendations, Reference Committee No. 2

Resolution J on Family Practice, presented by the Board of Trustees, was reviewed and discussed. The reference committee recommends the adoption of this resolution as written.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 2 as a whole.

(Seconded and carried)

As Chairman of Reference Committee No. 2, I wish to express my thanks to the members of the committee who are, Doctor Jones, Doctor Richards, Doctor Scott, and Doctor Trover. Their careful and mature consideration of the matters brought before the reference committee is greatly appreciated. Thanks are also due our secretary, Miss Pat Borders.

REFERENCE COMMITTEE NO. 2
Donn L. Smith, M.D., Louisville Chairman
Max P. Jones, M.D., Pikeville
Glen Richards, M.D., Lewisport
Carl Scott, M.D., Lexington
Faull Trover, M.D., Madisonville

REFERENCE COMMITTEE NO. 3

James B. Cox, M.D., Hopkinsville, Chairman

Reference Committee No. 3 considered the following reports:

5. Report of the Chairman, Board of Trustees, KMA-KNA Joint Advisory Committee Report Only
24. Report of the Committee on Occupational Health, Physical Medicine and Rehabilitation
25. Report of the Maternal Mortality Study Committee
31. Report of the Committee on Legislative Activities
32. Report of the Committee on Communication and Health Education
33. Report of the Committee on Health Careers
34. Report of the Committee on Community and Rural Health
35. Report of the Cults Committee

Resolution A—Sewage Systems (Fayette County)
Resolution G—Pollution (Jefferson County)

KMA-KNA Joint Advisory Committee

The single meeting of the KMA-KNA Joint Advisory Committee was held this year on May 15. The meeting was well attended by representatives of both associations, and a cooperative desire to strengthen liaison between the two groups was evident.

Your chairman had the honor of representing KMA at the AMA Committee on Nursing's Second

Annual Conference which was held during April in Chicago. A number of suggestions offered at that meeting were brought back for consideration by our state joint advisory committee. Hopefully, the implementation of these suggestions will enable the KMA-KNA Joint Advisory Committee to more fully and efficiently realize our purposes and goals.

Beginning with the next Associational year, we are planning to meet at regular four month intervals. We have requested the Executive Committee to recommend the appointment of committee members on a regional basis, which may necessitate the enlargement of the committee. When this is completed, each committee member will be asked to work with a local member of the nurses' committee on problems which may arise at the local level, or on tasks assigned them when the committees meet jointly. We also plan to invite representatives of the Kentucky Hospital Association to all future meetings.

The committee spent a great deal of time preparing and discussing statements to be issued jointly by the Kentucky Medical Association and the Kentucky Nursing Association. These proposed statements are offered here for consideration and action by the House of Delegates:

Joint Statement on Cervical Cancer Detection and the Role of the Registered Nurse

Kentucky Medical Association
Kentucky Nurses' Association

To promote good patient care, and protect the physician, the registered nurse, and the institution or agency, the Kentucky Medical Association, and the Kentucky Nurses' Association recognize the right of the registered nurse to take cytological cervical smears for cancer as one of the methods of determining if cancer is present, under the following conditions:

1. The nurse has the necessary special training and demonstrates a competancy to perform the function.
2. The procedure be performed under the supervision (direct or indirect) of a physician.
3. The procedure be performed in an agency or institution within the framework of an organized clinic or upon direct order of a physician.
4. The nurse records her observations for referral and use by the physician in making his diagnosis.
5. The physician directly responsible shall write an authorization for the R.N. to perform this procedure.

Joint Statement on the Role of the Registered Nurse in Glaucoma Screening Tests

Kentucky Medical Association
Kentucky Nurses' Association

To promote good patient care and protect the physician, the registered nurse, and the institution or agency, the Kentucky Nurses' Association and the Kentucky Medical Association acknowledge their acceptance of the propriety of a registered nurse to take tonometric reading as a screening procedure for the detection of Glaucoma, under the following conditions:

1. The nurse has the necessary special training and demonstrates a competancy to perform the function.
2. The procedure be performed under the supervision (direct or indirect) of a physician.
3. The procedure be performed in an agency or institution within the framework of an organized clinic or upon direct order of a physician.
4. The nurse records her observations for referral and use by the physician in making his diagnosis.
5. The physician directly responsible shall write an authorization for the R.N. to perform this procedure.

Joint Statement on Tuberculin and Other Skin (Allergy) Testing and Interpretation

Kentucky Medical Association
Kentucky Nurses' Association

Tuberculin skin testing has been recognized as an accepted means of identifying the infected population and allergy (skin) testing is an accepted method for identifying allergens and thereby arriving at appropriate treatment measures.

To effectively treat infected or affected individuals, certain tests are necessary forerunners of treatment.

Therefore, registered nurses may administer and read tuberculin skin tests if the following conditions exist:

1. The nurse has had competent teaching techniques.
2. The nurse performs these techniques upon the order of a licensed physician either as a direct written order or by standing written policies within the organization or institution in which she is employed.
3. If there is a direct line for communication and consultation if any question arises.
4. If there are established practices for reporting and recording positive reactions.

Joint Statement on Inhalation Therapy

Kentucky Medical Association
Kentucky Nurses' Association

Modern and improved systems of patient care have resulted in an expansion of responsibilities and functions in the practice of nursing.

The registered nurse is responsible professionally and legally for the administration of medications or treatments as prescribed by the licensed physician.

Inhalation therapy programs are becoming increasingly a part of patient care in hospitals. The organization for delivering such services to patients in hospitals is under various administrative structures, such as the department of anesthesiology, or the pulmonary, or under nursing service. It is recommended that such a program be under a specific department such as anesthesiology, or pulmonary, or nursing service under the supervision of a qualified physician of the active medical staff.

A specific order as to type, interval, duration of medication on each case will be written by the attending physician.

To promote good patient care, a committee in each institution or agency shall:

(a) Decide if the registered nurse may perform the technique.
(b) Determine the preparation to be required of the registered nurse.
(c) Establish inservice teaching.
(d) Establish the technique or techniques to be used.

Appropriately prepared personnel may administer inhalation therapy provided:

(a) Those performing inhalation thearpy shall be required to demonstrate satisfactorily:
 (1) The ability to operate and maintain the necessary equipment.
 (2) Knowledge of the dosage and effect of any solution or medication used.
 (3) Knowledge of how to clean the equipment and most important the sterilization of the equipment, changing the solutions, etc.

(b) There shall be communication and joint planning between the registered nurse responsible for the patient's total nursing care and the inhalation therapist, technician, or other person before, during and after treatment.

(c) There should be written policies relative to paragraphs (a) and (b), and such policies are to be available to all involved in the patient care. These policies shall be established jointly by representatives of hospital administration, the medical, nursing and inhalation therapy staff.

Joint Statement on Cardio-Pulmonary Resuscitation

Kentucky Medical Association
Kentucky Nurses' Association

Because each patient must be given the best available care, and because nurses deserve legal protection in these situations, and because the rising number of Intensive Care Units and/or Coronary Care Units now being established throughout this State have made it necessary, and because nurses are taking a greater responsibility in the immediate implementation of emergency treatment, this committee feels that there is a critical need for a policy statement which will spell out two fundamentals: first, the level of education and specialized training these nurses must have achieved; and second, which defines the scope and limitations of nurses' responsibility within the professional and legal aspects of nursing practices.

First, nurses in charge of these units should have intensive and comprehensive training in Cardiac emergencies; this specialized training should be in institutions qualified to give such training. This training should include the following: basic electrocardiography, use of cardiac equipment (monitors, defibrillators, pacemakers, etc.), the use of cardiovascular drugs, the signs and symptons of impending cardiac emergencies, and closed cardiac massage.

All personnel assigned to these units should have had a course in closed cardiac massage, mouth to mouth resuscitation, basic knowledge of the monitor, and any non-medical procedure they may be called upon to perform in an emergency. These programs should be under the direction and supervision of the physician in charge of the Intensive Care Unit and/or Coronary Care Unit and/or the Chief of Medical Service and the unit supervisor.

Each hospital should have an emergency team with trained personnel available at all times, and each person should be trained for a specific duty. These persons should be trained in the instituting of immediate emergency procedures and should be under the direction of the nurse assigned to supervise emergency care until the physician arrives. If no physician is immediately available, and from all indications death is imminent, the nurse in charge of the Intensive Care Unit and/or Coronary Care Unit should be prepared to defibrilate the patient and to initiate emergency drug measures.

Every hospital with an Intensive Care Unit and/or Coronary Care Unit and/or emergency team must have written policy governing the duties and responsibilities of those persons so assigned. These policies should be approved and agreed to and signed by the Medical Staff and nursing and hospital administration, and should be reviewed jointly at regular intervals. (Basic policies should not be left to each hospital, but should be set up according to a joint statement of the Kentucky Nurses' Association, Kentucky Medical Association and the Kentucky Hospital Association).

Joint Statement on Administration of Anesthetic By a Nurse Other than a Nurse Anesthetist

Kentucky Medical Association
Kentucky Nurses' Association

There is a practice in some areas of the state of Kentucky of allowing unqualified persons to administer anesthetics. According to an article in *The Journal of the Kentucky Medical Association,* published in April, 1968, by William E. Hopkins, M.D., entitled "A Survey of Current Anesthetic Practice in Kentucky", which is a report from a questionnaire mailed to all hospitals belonging to the Kentucky Hospital Association, anesthesia coverage in parts of the state does not insure safe, quality patient care and is far from adequate.

Only 15 of the 76 hospitals in which obstetrics is practiced indicated that a physician other than the obstetrician was present during obstetrical anesthesia. Obstetrical coverage on the whole leaves much to be desired throughout the state, except in the larger populated areas. Something is amiss when the obstetrical service of a hospital must depend on lay personnel to give obstetrical anesthesia. A hospital administrator added this comment, "OB anesthesia, 24 hour coverage, a constant 'thorn'". It is the patients in our smaller hospitals that suffer from the lack of trained anesthetists and anesthesiologists.

Who is qualified to administer anesthesia is a question we asked the Joint Commission on Accreditation of Hospitals.

The person giving the anesthetic, whether he be a physician or a C.R.N.A. must be qualified to give that anesthetic. The hospital staff must judge the person and determine whether he or she is qualified to give anesthetics. What the person is qualified to do should be delineated.

To give anesthetics, the person must be qualified by training and experience to give anesthetics and that these qualifications have been carefully investigated by the appropriate authorities in the hospital.

A registered nurse who gives an anesthetic to a patient assumes all the legal responsibilities that an anesthesiologist, a C.R.N.A., or a physician assumes in performing the same task. The Joint Commission on Accreditation of Hospitals insists that in order to give anesthetics, the person must be qualified by training and experience to give anesthetics and that these qualifications have been carefully investigated by the appropriate authorities in the hospitals. The JACH Manual states that a hospital should never allow anyone but an anesthesiologist, a C.R.N.A. or a qualified physician to give anesthetics in the hospital.

Malpractice implies negligence in the care of a patient or failure to employ methods, agents, or skill ordinarily considered appropriate. One definition of the duty of the anesthesiologist and the standards of care has been set forth as follows: "persons undertaking to administer anesthetics in the course of medical or dental treatment . . . are not insurers against harm nor guarantors of a favorable result, but are required to exercise ordinary or reasonable

care of skill under the circumstances; that is, the skill and diligence of the ordinary person engaged in similar practice at the time, and in the locality where the defendant undertook to act".

Proof of malpractice can be established in several ways. The most common requirement is that the plaintiff produce expert testimony *establishing the standard of medical care applicable to the specialty involved.*

During anesthesia, the anesthesiologist must exercise reasonable care in the protection of the patient against injury. In the event that the anesthesiologist employs new techniques, equipment or agents, he should be able to substantiate the fact that he is familiar with these and understands the complications that may arise from their use.

Introduction to Anesthesia - Dripps/Eckenhoff/Vandam)

In view of the above information and looking at the preparation and training of the registered nurse, we firmly believe that it is wrong for a registered nurse who has not been certified in an approved school of anesthesiology to give an anesthetic to any patient, either surgical or obstetrical. Professionally, she is not trained to execute the function, legally she is not licensed for this duty, and due to the shortage of nursing personnel, she cannot give adequate patient care if she is trying to be a "physician" too.

Therefore, we state than an anesthetic should be given *only* by a qualified, prepared individual such as an anesthesiologist, a physician, a dentist or a C.R.N.A.

We are of the opinion that much can be realized from the KMA-KNA Joint Advisory Committee in that problems which may affect the nursing profession, the medical profession and health care generally, can be brought out and discussed openly before becoming widespread.

The members of both committees are to be recognized for their interest and cooperation. As Chairman for the physician committee, I would especially like to thank the physician members for their cooperation this year.

A. Evan Overstreet, M.D., Chairman

BOARD ACTION: Recommend it be disapproved as incapable of effective implementation at this time.

Recommendations, Reference Committee No. 3

The KMA-KNA Joint Advisory Committee Report, which was included with the report of the Chairman of the Board of Trustees, was reviewed by Reference Committee No. 3. Many points of value have been brought forth by this hardworking committee. We feel, however, that before acting upon the individual recommendation concerning the physicians' relationship with ancillary medical personnel, guidelines must be established.

To recommend approval of such far-reaching programs, which affect such a wide variety of physicians and hospitals, is not, in our opinion, wise at this time without further comprehensive study.

The committee is grateful to the KMA-KNA Joint Advisory Committee for their efforts and encourages the continued work along the lines previously mentioned.

Mr. Speaker, for the above reasons, I move that we accept this section of the report for information only.

(Seconded; carried)

Report of the Committee on Occupational Health Physical Medicine & Rehabilitation

Your Occupational Health, Physical Medicine & Rehabilitation Committee has met on two occasions during this Associational year, May 14 and June 4.

Last year this committee endorsed the Kentucky Department of Health providing an Employees Health Service for state employees. The 1968 session of the House of Delegates requested this not be implemented without the agreement of the Franklin County Medical Society. Additional information on this matter is being sought by this committee.

The subject of "Black Lung" received a lengthy discussion in both of our meetings. We have recommended to the Board of Trustees, for consideration at their August 7 Board meeting, that an ad hoc committee composed of representatives of interested groups be appointed to study Black Lung.

The committee has initiated a study of the functions of the Environmental Health Division of the Kentucky Department of Health. Much discussion has been held by committee members concerning the need for at least part-time consultation with a physician on matters which come under the jurisdiction of the Environmental Health Division. The committee felt it was unlikely that a full-time physician would be added to this division staff, but recommends that budgeting of some state and/or federal funds be used for medical consultation services on matters under the jurisdiction of the Environmental Health Division which may affect the public health status in Kentucky.

We continue to pursue our interest to see that all injured workers be rehabilitated so they can become requalified for employment. It is felt that some changes could be made in our Workman's Compensation Laws to facilitate this goal. Plans are being made to submit recommendations to the Board of Trustees for possible legislative action in this field.

Other matters brought before this committee for consideration this year included Air Pollution, Water Pollution and Noise Pollution.

The chairman is grateful for the time and effort expended by the committee members this year.

John E. Eckerle, M.D., Chairman

BOARD ACTION: Approved. For the information of the House of Delegates, the Board of Trustees has authorized the appointment of an ad hoc committee to study "Black Lung."

Recommendations, Reference Committee No. 3

The Report of the Committee on Occupational Health, Physical Medicine and Rehabilitation was reviewed. It was felt by this committee that the term Black Lung should be substituted by a more meaningful term such as Occupational Pulmonary Diseases. We note that an ad hoc committee to study this problem has been authorized by the Board of Trustees.

The reference committee encourages the committee to continue their interest in legislation affecting the Workmen's Compensation Laws.

We would like to express our appreciation to this committee for its effective work in this field of occupational medicine.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee of the Kentucky Medical Association had two meetings since the last report. The Committee reviewed and thoroughly discussed the protocols of all maternal deaths that had occurred in Kentucky through the previous year. Each death was classified as to whether it was of direct or indirect obstetric cause, and any identifiable preventable factors were recorded.

Selected protocols from the Committee's files were published monthly in the Journal of the Kentucky Medical Association, together with resumes of the Committee's comments. The Committee recommends that this page be continued for the coming year, as it would seem to have considerable potential educational value.

The Committee wishes to suggest the possibility of making available helicopter transfer of some emergency obstetric cases from remote areas to well equipped medical centers as one practical measure that could be taken to help reduce maternal mortality in Kentucky. It would be ready to act in an advisory capacity to plan such an emergency transportation program.

Douglas M. Haynes, M.D., Chairman

Recommendations, Reference Committee No. 3

The Report of the Maternal Mortality Study Committee was reviewed by this committee. We would like to commend the Maternal Mortality Study Committee members on their effective work.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Committee on Legislative Activities

National Affairs

The Committee on Legislative Activities has met on two occasions this year. Various bills submitted to the current session of Congress were reviewed. As usual, there was a large plethora submitted having to do with health affairs. There had been none under serious consideration or necessitating any remarkable approach in behalf of either support or condemnation from our State Medical Association at this point. To date, there had been introduced some 5000 bills of which about 1100 had medical connotations.

The Washington Dinner was held on May 13, 1969, in Washington, D. C., with a tour of the Capitol and a visit to each of our seven representatives and two senators. General discussion, both for current circumstances, historical happenings and projections in the future, were carried out in each instance. This was the largest turnout of doctors and their wives that we have had to this occasion. The affair was concluded with an evening dinner at the Mayflower Hotel, where all of our representatives and senators were present, along with their administrative assistants and, in most instances, their wives. It was generally concluded that this was a most satisfactory meeting, even though there was no real confrontation in regard to support or denial of any current legislative projects.

During the critique in the afternoon of May 13, some general reconsiderations of the Washington Dinner were undertaken. It was agreed by everyone at this time that it should be an annual affair, that it is most worthwhile, and that our approach and contacts in many instances will be quite rewarding and helpful to continuing quality health care.

Some other suggestions were made in order to improve this dinner; namely, (1) that there be a briefing session on Monday night preceding the Congressional Dinner rather than the early morning briefing session, (2) that more information on congressmen be sent prior to the meeting along with a biographical sketch of the individual congressman, (3) a map showing directions around the Capitol be provided to help mobility and quick identification of buildings.

As this is a state election year in Kentucky, we have been trying to supply information in regard to legislative records to be helpful to those interested parties, judging the past performances of our senators and representatives at the state level. It was taken of note of the overwhelming success of recent activities of KEMPAC in regard to the state election, and it is felt that this will prove helpful also, as some of the leadership evolves to the national level.

Appreciation on behalf of the KMA Committee on Legislative Activities and National Affairs is to be extended to Gil Armstrong, Jerry Mahoney, along with thanks to Robert Cox, executive secretary, for their outstanding help and aid to us during this past year.

Hoyt D. Gardner, M.D.
Chairman for National Affairs

State Affairs

This being a year in which the Kentucky General Assembly did not convene, it was necessary for the Committee on Legislative Activities to meet on only two occasions, the first being November 7, 1968, which was a joint meeting of the KEMPAC Board of Directors and the KMA Committee on Legislative Activities, and on June 6, 1969. The full activities and participation on behalf of KMA by the committee members is not necessarily reflected by the number of committee meetings held. The members of our committee have attended meetings other than the Legislative Activities Committee meetings, and the chairmen and other committee members also attended the Congressional Dinner in Washington and the AMPAC Workshop in Washington, as well as some KMA Trustee District meetings.

Two legislative items which have carried over into this year from the prior year were House Bill 495 relating to the Kentucky Tuberculosis Commission and the operation of the tuberculosis hospitals, and House Resolution 86, dealing with the composition and functions of the State Board of Health. Both matters have been referred to the KMA Executive Committee, and, following several consultations and meetings with various groups and individuals concerned with the problems, a task force has now been formed to study the operation of the tuberculosis hospitals and make recommendations as to improvements and desired changes for the benefit of the profession, as well as the Commonwealth. Study is also underway on House Resolution 86, and recommendations as to the composition and functions of the State Board of Health will be submitted to the Legislative Research Commission for consideration.

As during the last session of the General Assembly, it will once again be the concern of the Committee on Legislative Activities to present positive legislation concerning medical matters. Already acted upon in the field of positive legislation is the Uniform Anatomical Gift Act and a state law permitting Minor's Consent to VD Therapy.

Our previously proposed first aid station remains under consideration. We are most appreciative for the commitment from Fayette County to staff the

first aid station if and when satisfactory space can be obtained.

The committee is most grateful to the House of Delegates for its action at the last Annual Meeting requiring all legislative activities to be coordinated by and channeled through the Committee on Legislative Activities. We feel that this is a most important consideration, and our committee will continue to place emphasis on cooperation between our committee and all specialty groups and individual physicians wishing to introduce various legislative proposals. The channeling of such legislative matters through a specific committee not only keeps our entire profession informed rather than a segment thereof, but also gives us an opportunity to study the legislative matter under consideration in an effort to present to the Legislature the best possible draft we can obtain on a particular legislative matter. To have broad-based medical support of a bill also enhances its passage.

The committee's efforts will continue in the area of communication in an effort to maintain open communication with all of the allied professions, including the State Department of Health, the University of Louisville School of Medicine, the University of Kentucky College of Medicine, the Kentucky Hospital Association, the Kentucky Dental Association, the Kentucky Pharmaceutical Association and other allied groups.

Efforts continue to strengthen our key man system, and the recommendations of local medical societies for various key man appointments are being heavily weighed in the selection of key men. This committee wishes to emphasize the extreme importance of the key man system and the *absolute necessity* for each key man to respond *each* time he is called upon, whether it be once every three months or three times a day. The key men must realize that without their help and cooperation, the communicative system cannot adequately function and the profession of medicine, as well as the Commonwealth of Kentucky, will be the losers when they do fail to function. Each man should understand that he will probably be contacted several times on the same legislative matter as the situation might change in Frankfort. It is just as important for him to respond to the second or last call as it was for him to respond to the first.

The Committee on Legislative Activities is also most grateful to the KMA House of Delegates for the manner in which it has acted upon legislative proposals presented before the House, leaving the priority of various legislative proposals up to the Legislative Activities Committee, as well as the timetable to be used on the introduction of proposed legislative matters. I feel that this is an extremely important consideration and would urge the 1969 House of Delegates to take similar action leaving the composition, priority and manner of introduction to the Committee on Legislative Activities. This is the only logical approach to assume, and I shall be delighted to appear before any group or committee to offer any additional information or further discussion if any question should arise.

We are fortunate in having obtained a full-time staff man for legislative activities since the last Annual Meeting, and, although he will not have been employed by KMA for a full year prior to the next General Assembly, it is the feeling of the committee that he will be of tremendous benefit to the Medical Association and will enable us to have two field representatives in Frankfort during the legislative session rather than one. In the past it has proven a physical impossibility to adequately cover activities of both the Senate and the House simultaneously during the legislative sessions.

Although the 1967 House of Delegates passed a five dollar dues increase earmarked for legislative affairs, it is the feeling of this committee that this amount of money is inadequate as was reported in our annual report last year. We anticipate the necessity of a total of ten dollars per member dues increase to adequately cover the salaries and expenses of the staff men concerned with legislative activities.

Once again it should be the understanding that the field men are responsible only to their immediate superiors and not to individuals located throughout the state. This has proven to be a problem in the past, and certainly we would hope that this would not present itself as a problem in the future during the General Assembly session. The field men have been instructed not to carry out any recommendations or suggestions presented to them by anyone without first the approval of this committee or its proper representatives.

Once again this committee cannot emphasize frequently enough nor loudly enough the absolute necessity of physicians participating at the local level, not only in legislative affairs, but in primary and general elections as well. So often the members of our committee hear from legislators that the physicians in their local area have not been in contact with them. We urge all physicians to become interested in legislative matters and to stay abreast of legislative trends and effectively communicate their opinions to their respective legislators. We also strongly urge each physician to support the candidate of his choice both financially and by active campaigning on behalf of the candidate. It is extremely important for all physicians to maintain rapport with their legislators, and, even more so, for the key men so assigned.

In some areas, local physicians and their wives have hosted a social for all legislators in their respective area, whether it be by county, senatorial district or congressional district. Legislators from both parties are invited, and assigned key men escort their respective legislator to the event. This committee strongly endorses such events to improve rapport with legislators and urges all congressional key men to initiate such events within their respective district, location and area involved to be determined by the congressional key man.

It is also the recommendation of this committee that the "Quick Action Committee," composed of the KMA President, President-Elect, and Chairman of the KMA Board of Trustees be empowered to approve legislative decisions presented to them by this committee. It is absolutely impossible during legislative sessions to wait considerable periods of time for formal approval of legislative matters by larger committees.

I wish to express appreciation to those members of the Committee on Legislative Activities, to the "Quick Action Committee," to the KMA Board of Trustees and to the KMA House of Delegates for their considered support and understanding. I am also very grateful to our staff, Bob Cox, Gil Armstrong and Jerry Mahoney, and I must say that they have been extremely cooperative and of tremendous benefit to the chairman and to our committee as a whole.

Fred C. Rainey, M.D.
Chairman for State Affairs

Recommendations, Reference Committee No. 3

The Report of the Committee on Legislative Activities was reviewed.

National Affairs: The Report of the Committee on Legislative Activities, National Affairs, was reviewed. This committee continues to keep abreast of the national political activities, and its outstanding work is to be commended.

The reference committee concurs with the suggestion of a briefing session on Monday evening prior to the Congressional Dinner. A biographical sketch of the individual congressman, along with a

map showing directions around the Capitol, is also an excellent suggestion.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

State Affairs: The Report of the Committee on Legislative Activities, State Affairs, was reviewed. It is recommended that legislative proposals continue to be channeled through the Committee on Legislative Activities. In addition, we recommend the "Quick Action Committee," composed of the KMA President, President-Elect, and Chairman of the Board of Trustees, be empowered to approve legislative decisions presented to them by this committee.

Although this has not been an active year for State Affairs politically, the reference committee would like to express its appreciation to the Committee on Legislative Activities.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Communication and Health Education Committee

The Communication and Health Education Committee had one meeting during the 1968-1969 Associational year. This meeting was held January 9, 1969, and the following items of business were given our consideration, and appropriate recommendations were made:

1. *KMA Exhibits*

Recommendation was made to the Board of Trustees that exhibit space be secured at the 1970 KEA Convention to be used by the KMA School Health, Physical Education and Medical Aspects of Sports Committee. This has been and continues to be an outstanding exhibit.

2. *New Member Orientation Program*

Detailed plans were made for the Eighth Orientation Course to be presented at the Interin Meeting in Lexington. The same format will be followed, and the same speakers will be invited to once again participate.

All of these speakers, both lay and physicians, are to be highly commended for their devoted and loyal service to KMA through their excellent work in this program.

3. *Health Careers*

Five Health Careers kits were distributed in strategic places throughout the state with the hope of stimulating interest in these various paramedical fields.

4. *Speaker's Bureau*

This committee continues to supply speakers for both lay and professional talks, on request.

N. L. Bosworth, M.D., Chairman

Recommendations, Reference Committee No. 3

We reviewed the Report of the Committee on Communication and Health Education. Comments were heard pertaining to the Orientation Program. It is the opinion of the members of this reference committee that some consideration should be given to reviewing the format of the Orientation Course with special emphasis on brevity and informality.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Health Careers Committee

This year, the Health Careers Committee continued its efforts in full support of and in cooperation with "Health Careers In Kentucky".

In addition to revising the folder on Careers in Medicine, the individual members were involved in specific recruitment at the local and county levels coordinating their efforts with those of the district committees of Health Careers In Kentucky.

Requests for information from students interested in medicine are being channeled by Health Careers In Kentucky to both of the Commonwealth's Medical Schools as well as to the Kentucky Medical Association.

This committee will develop plans to coordinate its communications with those of the schools to insure the proper level of response to those requests.

Finally, although it is impossible in this report to recognize by name the many individuals, particularly our Auxiliary members who continue to work tirelessly in the development, planning and implementation of a variety of recruitment programs throughout the state, the committee feels it appropriate that we use this report to assure them of their Association's gratitude.

Joseph Hamburg, M.D., Chairman

Recommendations, Reference Committee No. 3

The Report of the Committee on Health Careers was reviewed. We wish to thank this committee for its fine contributions.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Committee on Community and Rural Health

Your Community and Rural Health Committee met at the Headquarters Office on March 20, 1969. The initial part of our meeting was devoted to a review of the duties of the committee for the information of new committee members. Briefly, this committee has the responsibility of continually investigating means for bettering all aspects of public and mental health in Kentucky, studying all aspects of TB and TB control, and as an objective, the decreasing of deaths and disabilities caused by motor vehicles.

During the week of May 4-10, we once again promoted Immunization Week in Kentucky, and wish to express our appreciation for the cooperation of the membership in this program. In addition, we received considerable assistance from numerous allied organizations, for which we are grateful.

In the past, this committee has encouraged the promotion of Community Health Week by the county medical societies. Next year, the committee will assume the task of promoting Community Health Week in conjunction with Immunization Week, during May. Hopefully, this will help to emphasize local medical progress, available health facilities and services, and the individual and cooperative roles played by members of the community health team.

In the area of Rural Health, Resolution I (Home Health Care) was referred to us for implementation by the KMA Executive Committee. This resolution, passed by the 1968 KMA House of Delegates, encourages physician interest and participation in the

Home Health Care Program. Your committee felt that physicians should be aware of this program and felt that the best method of implementation was through the component county society secretaries, who have now received material on this.

Our committee maintains liaison with representatives and agencies that have similar interests in the areas of responsibility assigned to us. This year, we have contacted the Kentucky Bar Association in an effort to establish liaison in the area of alcoholism, which is a legal as well as a medical problem.

Highway safety continued to be of major interest to us. Through our committee, in cooperation with KMA, the second three-year Kentucky Automotive Crash Injury Research Program has recently been completed. This study is concerned with injuries and fatalities in late model automobiles. In addition, we are maintaining our leadership in the Kentucky Driver Limitation Program.

We continue to vigorously promote the KMA Automotive Safety Award which has now been presented to 13 organizations who have agreed, or have required their employees, to wear seat belts anytime they drive a motor vehicle.

The committee also discussed the Slow Moving Vehicle Emblem and its usefulness in helping to prevent highway accidents. It was taken by consent to introduce the following resolution on the Slow Moving Vehicle Emblem to the members of the KMA House of Delegates and urge its adoption:

WHEREAS, The Slow Moving Vehicle (SMV) Emblem has aroused national interest because of its potential for identifying, on public roads, slow moving vehicles with speed capabilities of less than 25 miles per hour, which include vehicles such as farm tractors and other farm vehicles, road maintenance and construction equipment, and horse-drawn vehicles; and

WHEREAS, The SMV Emblem, developed from research at the Ohio State University, is a 14 inch equilateral triangle with a fluorescent orange center for daytime visibility and a reflective red border for nighttime, which when properly mounted on the center rear of a vehicle, two to six feet from the ground, can be seen and identified from 500 feet or more, both day and night; and

WHEREAS, The American Society of Agricultural Engineers and the Society of Automotive Engineers have developed specifications for physical properties, dimensions, component materials, and use of the emblem; and

WHEREAS, The Board of Directors of the National Safety Council approved a Policy Statement on the SMV Emblem which formally confirms full Council support for the promotion and use of the SMV emblem, urges that every effort be made to encourage emblem use on slow moving vehicles, and to educate the public to recognize it as identifying a slow moving vehicle; and

WHEREAS, Even though a number of states have passed enabling legislation on the use of the emblem and progress is being made, increased emphasis is needed to secure national adoption and use of the emblem; therefore be it

RESOLVED, That the Kentucky Medical Association officially endorse the SMV Emblem and the objectives for which it stands; and be it further

RESOLVED, That the Kentucky Medical Association, in cooperation with county medical societies, promote the use of the emblem on slow moving vehicles and help to educate the public to recognize it as identifying these vehicles.

Because of our varied duties, the Community and Rural Health Committee is composed primarily of physicians who have chaired KMA Committees in the past on the specific subject areas which have been assigned to us; that is, mental health, public health, tuberculosis and highway safety. I am deeply indebted to these committee members for their participation and leadership in their areas of responsibility this past year.

Ralph D. Lynn, M.D., Chairman

Recommendations, Reference Committee No. 3

We reviewed the Report of the Committee on Community and Rural Health. We commend this committee on its interest in automotive safety.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Committee on Cults

This has been an active year for the Committee on Cults. Kentucky was well represented at the AMA/National Health Council Fourth National Congress on Health Quackery held in Chicago on October 2-3, 1968. The meeting was attended by state officials, representatives of the Kentucky State Department of Health, by the chairman for State Affairs of the KMA Committee on Legislative Activities, the chairman of the KMA Committee on Cults and one KMA staff member.

The committee has met on two occasions, on December 11, 1968, and February 12, 1969. Studies were made of potential quackery in the treatment of dyslexia by the unqualified and the sale of hearing devices by non-specialists. Reports of the information obtained have been provided to the appropriate medical specialty groups.

The committee constantly surveys cult advertising and is pleased to report that there has been a marked reduction each year since the passage of the legislation restricting advertising or soliciting by practitioners of the healing arts passed by the 1966 session of the Kentucky General Assembly. In a 1968 circuit court case in Fayette County, chiropractic advertising was denied and the constitutionality of the law was upheld (Rose versus the Lexington Herald Leader and the State of Kentucky).

The recommendation has been made by the committee that consideration be given to legislation which would limit the use of human x-ray. A suggested draft along this line has been submitted to the KMA Committee on Legislative Activities.

In January of this year two reports were issued, independent of the medical profession, on chiropractic practitioners. The United States Department of Health, Education and Welfare conducted an exhaustive study of the chiropractic profession and concluded that chiropractors who claim they can cure disease by spinal adjustments are so poorly educated that they cannot adequately diagnose or appropriately treat human disease. The Department has recommended that chiropractic services not be covered under the Medicare Program.

The National Council of Senior Citizens, which represents more than two million health care consumers, has also called for the continued rejection of all attempts to include chiropractors under Medicare. The Council labeled chiropractic a cult.

There is no doubt that medical quackery represents a tremendous loss to our economy, in addition to the health hazard it imposes on the public. Members of the Committee on Cults are most cognizant of their responsibility to the Association and the public.

David B. Stevens, M.D., Chairman

Recommendations, Reference Committee No. 3

The Report of the Cults Committee was reviewed. We wish to encourage this committee to continue its outstanding work on this most important subject.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Resolution A

Fayette County Medical Society

WHEREAS, this community must protect its health and must be responsible for the protection of those whose water supplies are downstream; and

WHEREAS, evidence is available that many present local sewage systems are being operated inadequately and causing pollution; and

WHEREAS, permits for sewage systems are being granted by state authorities without prior approval of the local Board of Health; be it

RESOLVED, that the Fayette County Medical Society, through the Legislative Committee of the Kentucky Medical Association, work through legislation to add control by the local Board of Health of present and future sewage systems.

Recommendations, Reference Committee No. 3

Resolution A, Sewage Systems, introduced by the Fayette County Medical Society, was reviewed. The committee recommends approval of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Resolution G

Jefferson County Medical Society

WHEREAS, the Kentucky Medical Association has always concerned itself with the health and well-being of the citizens of Kentucky, and

WHEREAS, air and water pollution are present in our state and constitute a grave danger to the well-being of the total population, and

WHEREAS, measures to better this condition have not met with noteworthy success, therefore be it

RESOLVED, that the Kentucky Medical Association create a standing committee charged with assisting in correcting air and water pollution through

1) Helping establish standards necessary to guarantee air and water suited to human use.
2) Giving full support in areas of legislation, regulation, and education so that proper measures may be effectively implemented and their necessity for acceptence recognized by all.

Recommendations, Reference Committee No. 3

Resolution G, Pollution, introduced by the Jefferson County Medical Society, was reviewed. The committee recommends approval of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 3 as a whole.

(Seconded and carried)

Mr. Speaker, I would like to thank the members of my committee for their assistance and on their behalf to thank our secretary, Mrs. Bobbie Coogle.

REFERENCE COMMITTEE NO. 3

James B. Cox, M.D., Hopkinsville, Chairman
Cecil Grumbles, M.D., Louisville
David A. Hull, M.D., Lexington
John S. Oldham, M.D., Owensboro
Charles B. Stacy, M.D., Pineville

At this time, Doctor Greathouse introduced John C. Quertermous, M.D., Chairman of the KEMPAC Board of Directors, to present his annual report to the members of the House concerning KEMPAC activities. Doctor Quertermous summarized the year's accomplishments, calling special attention to the fact that membership in KEMPAC is at such an all-time high that Kentucky has an opportunity to win national honors. He then made the following motion which was seconded and passed:

"That the KMA House of Delegates reaffirm its belief in the objectives of KEMPAC and AMPAC and recommend 100 per cent participation by doctors and their wives; that the House also reaffirm KMA policy that there be county society billing in order to encourage this participation; and finally that the House give a vote of endorsement and encouragement of the KEMPAC organization to continue its worthwhile political efforts on behalf of our free enterprise system and the freedom of the art and science of medicine."

REFERENCE COMMITTEE NO. 4

Edward N. Maxwell, M.D., Louisville, Chairman

Reference Committee No. 4 considered the following reports:

13. Report of the Kentucky Physicians Mutual, Inc., Board of Directors
22. Report of the Advisory Committee to Blue Shield
23. Report of the Advisory Committee to Blue Cross
36. Report of the Senior Day Committee
37. Report of the Committee on School Health, Physical Education and Medical Aspects of Sports
38. Report of the Advisory Committee to Woman's Auxiliary
44. Report of the Ad Hoc Study Committee for Improved Community Health
5. Report of the Chairman, Board of Trustees, Ad Hoc Committee on Insurance Forms Only

Resolution C—Insured Ambulatory Diagnostic Benefits (John Berry, Fayette County)

Resolution D—Kentucky Physicians Mutual "A" (Fayette County)

Resolution E—Kentucky Physicians Mutual "B" (Fayette County)

Resolution H—Kentucky Physicians Mutual "C" (Fayette County)

Resolution L—Usual, Customary and Reasonable Fees (E. B. Schoenbachler, Jefferson County)

Report of the Board of Directors Kentucky Physicians Mutual

This year marks the 20th anniversary of Blue Shield in Kentucky, and as Chairman of the Board of Directors of Kentucky Physicians Mutual, it is a privilege and a pleasure for me to make this annual report to you. We reached a major milestone this year in enrolling our millionth member.

In the 20 years of our existence in Kentucky, we have paid over $101,700,000 to doctors and pro-

cessed over 3,200,000 claims. In the past 12 months our payments amounted to $12,600,000.

As of June 30, Blue Shield membership was 1,013,982, which is a net gain of 4 percent in the last 12 months. There are 299,887 members now enrolled in Major Medical or Extended Benefits. In the same period, 972 additional employers enrolled their employees and dependents voluntarily in Blue Shield, making a total of 10,338 companies enrolled. Over 168,000 members increased their protection, which means that they are now paying higher dues. There are 53,000 people 65 years of age and over who are now enrolled in our "Over 65 Program" to fill voids in Medicare. Effective January 1, the government, because of financial problems, increased deductibles for people 65 and over, and I am pleased to advise you that we were able to absorb these increases on behalf of our members with no increase in rates.

Our Plan is sound financially and has reserves of $10.56 per member. We continue to operate with one of the lowest overhead costs per member of the 74 Blue Shield Plans in America. Of the Plans with more than a million members operating on a statewide basis, we rank second in low cost of operation per member.

During the past year, we formed on a statewide basis a distinguished Consumer Advisory Committee. The members voluntarily give of their time to work with us to improve the program and our public relations. We also established a College Student Plan and an experimental prepaid drug program.

Many firms, large and small, and unions as well as individuals are now demanding paid-in-full programs for covered services, with adequate peer review, and are willing to pay the necessarily higher dues for such a program. This offers us a tremendous opportunity to strengthen and expand the voluntary system and help channel voluntarily more money into the health system and provide a way for thousands more people to be in a financial position to pay doctors their usual and customary fees. It is also a positive vote of confidence in doctors. In the past nine months, under the usual, customary and reasonable program, we processed over 41,000 claims. Of these 41,000 claims, following the mechanism approved by the KMA Claims Review Committee, we are proud to report that it was necessary for Blue Shield to refer less than one-half of one percent to peer review committees. As requested by the Kentucky Medical Association, on July 14 we began offering the doctors of Kentucky the opportunity to participate or to not participate in this program.

The Kentucky Medical Association, 20 years ago, started Blue Shield for the people to help solve a socioeconomic problem, to help people voluntarily budget for health care and to be in a better position to meet their financial responsibility to their doctors. There were other objectives, also: to try to help prevent the socialization of medicine and further government encroachment, to strengthen the voluntary free enterprise system. This is a never-ending fight, and today we are still in the forefront. The furore over Medicaid has increased chances that Congress may turn as soon as next year to attempt to establish compulsory federal health insurance. A congressional task force recently urged such a program. A national powerful labor leader has formed a committee of one hundred to lobby for it.

We need the understanding and support of the doctors of Kentucky as well as that of the general public in all of our efforts. These are very crucial times. We fear that government regulation of fees may be only a few months off unless medicine demonstrates that it has a working mechanism for adequate peer review. Kentucky medicine is now developing this mechanism and is again demonstrating its responsibility. It is vital that it work to the satisfaction of not only the doctors of Kentucky but to members.

Our voluntary system for prepayment is strong; it is vital; it is growing. We have many dedicated people in and out of the profession who give of their time to make it work. We are extremely grateful to all of them. We know that what we are doing and that our objectives are in the best interest of the people, the medical profession and our voluntary system. We wish to extend to the members of the entire medical profession of Kentucky and to the staff of the Kentucky Medical Association our sincere thanks for their cooperation and contribution in helping make this another successful year.

Garnett Sweeney, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Kentucky Physicians Mutual, Inc., Board of Directors documented the growth and increasing protection of policies offered by Kentucky Physicians Mutual. We are pleased to note that the Plan is sound financially, with adequate reserves. The demand for paid-in-full policies with peer review is apparently increasing. The danger of compulsory federal health insurance as an alternative to these plans is pointed out, and the necessity for strong support of our voluntary prepayment system by the doctors is documented. Reference Committee No. 4 recommends that this report be adopted.

Mr. Speaker, I move the adoption of this section of the report. (Seconded.)

During the discussion, a motion was made and seconded that this report be amended to state that the Report of the KPM be accepted for information only. A division of the House was called and the amendment was defeated by a 67 to 33 margin. The original motion as stated was adopted.

Report of the Advisory Committee to Blue Shield

The Advisory Committee to Blue Shield met on April 24, 1969, with the KMA President, Chairman of the Board of Trustees, the Chairman of the KMA Claims Review Committee, and county review committee chairmen, officials of the Fayette County Medical Society, and representatives of Blue Shield in attendance.

The 1968 Report of this committee to the House of Delegates was reviewed with special attention given to the resolution contained therein reaffirming support of the usual and customary principle and calling for the establishment of peer review committees at the county and state levels.

Representatives of the Blue Shield staff reported that as of our meeting date, 11 county societies had established peer review committees and four more were in the process of doing so. The committee was pleased to learn that of all claims submitted under the usual and customary program, it was necessary for less than one-half of one percent to be sent through the review mechanism. This means that over 99½ percent of all claims submitted were paid routinely.

We also enthusiastically received a report indicating that a new milestone was reached in February of this year when the one millionth member of the Kentucky Blue Shield became a reality. The continuous efforts of Blue Shield to up-grade coverage of subscribers has resulted in a decrease from nearly 40 percent to only 26 percent of those who still maintain coverage on the Standard contract.

At the March 26 meeting of the KMA Board of Trustees, members of the Fayette County Medical

Society questioned whether or not the usual and customary program as adopted by the House of Delegates had been fully explained to Kentucky physicians so that they would be knowledgeable that through the peer review mechanism, those payments made were to be payment in full for the services covered under this program. Additionally, it was felt that there should be some mechanism available for any physician who might not desire to participate in this program. Since the original resolution was introduced by this committee, the entire matter was referred back to us for clarification. We are grateful to the Fayette County members for their willingness to attend our meeting and again reiterate those points they had presented to the Board for interpretation.

A full and lengthy discussion was held at our session. We initially reviewed the background for introducing last year's resolution which pointed out in the preamble that:

"The demands for paid in full coverage for physicians' services has been growing rapidly in the last few years. This demand has been accelerated by the advent of Medicare and Medicaid, and by the adoption by large national employers of the principle of payment of usual and customary fees. This principle of payment is also generally enthusiastically endorsed by the medical profession not only in Kentucky but all over the nation."

Following adoption of the resolution by the House of Delegates, the KMA Claims Review Committee was appointed and county review committees were activated. Information concerning the usual and customary program and the guidelines for implementing it were then distributed to KMA members through direct mailings, the KMA Journal, and the county society secretaries. Additional promotional efforts were initiated within the Blue Shield headquarters.

Part of the discussion emphasized that if our volunteer system does not create methods for the prepayment of medical care as demanded by the public, this role will be fulfilled within the government circles.

At the close of our meeting, and with the advice and consent of the President and Chairman of the Board, who were both in attendance, it was agreed that no new policies were being initiated as a result of this meeting but merely more detailed methods of implementation were being clarified. With this in mind, the following statement of policy was adopted with the understanding that Blue Shield is being asked to proceed with the implementation of those matters contained in this statement relative to its operation. While this is not a new policy statement, we do urge the concurrence of the Board of Trustees and the House of Delegates:

"The KMA Board of Trustees has received a communication from the Fayette County Medical Society questioning whether or not the Usual and Customary concept previously adopted in 1968 by the KMA House of Delegates is, in fact, a paid-in-full program.

After reviewing last year's report of the KMA Advisory Committee to Blue Shield and the information disseminated to Kentucky physicians since its approval, it is the opinion of this committee that this does represent a paid-in-full program for covered services.

1. The public is rapidly increasing its demands for paid-in-full type surgical-medical programs which will permit an individual to prepay for the full cost of covered services.

2. It is the official policy of the National Association of Blue Shield Plans that all individual Blue Shield Plans must have available this type of Usual and Customary program.

3. The American Medical Association officially endorses and promotes the Usual and Customary concept for payment of physicians fees by all third parties.

4. Without the paid-in-full concept, Usual and Customary has no meaning other than that of being just a high-priced indemnity program which cannot be sold in the marketplace.

5. In order to make the program operative, certain requirements are necessary. This committee recommends that the Usual and Customary and paid-in-full concept be one and the same with the following requirements recognized:

a. Physicians can signify their support of the Usual and Customary concept by being a 'participating' physician and by signing an agreement to that effect.

b. A physician who does not accept this concept could elect to not sign a participating physician agreement.

c. Participating physicians would agree to accept as payment in full allowances made by Blue Shield's Usual and Customary program for covered services using guidelines established by the KMA Claims Review Committee. Peer review committees, which are a part of these guidelines, will make the final recommendations for reasonable allowances on cases that cannot be processed routinely. Payments will be made direct to the participating physician.

d. Blue Shield's allowances for covered services rendered by non-participating physicians will be determined using the same guidelines as for participating physicians except payment for covered services will be made direct to the subscriber."

6. It is recommended that the KMA Board of Trustees, working in cooperation with Blue Shield, institute an immediate and continuing multi-phasic program of education to assist the profession and the public in the explanation and implementation of the Usual and Customary program.

7. It is further recommended that the Board of Trustees reaffirm the position taken by the 1968 House of Delegates and that it urge the Blue Shield staff to continue marketing the Usual and Customary program under the present guidelines, working toward obtaining individual participating physicians agreements."

Your committee continues to feel this matter to be of prime importance to the medical profession of Kentucky. We further feel that it is in the best interest of the individual physician and the profession for physicians to participate fully in the program and are confident this will be accomplished as KMA members become more knowledgeable of the program.

In our committee role, we strive to reflect the policies of this association and to provide assistance in the up-grading of Blue Shield coverage for all Kentuckians.

The 18 members of this committee have demonstrated their dedication to duty and their chairman is indebted to them for their time, efforts, and counsel.

W. Vinson Pierce, M.D. Chairman

BOARD ACTION: Approved, with the recommendation that a sub-paragraph (e) be added to paragraph 5 which would state: "A peer review committee with the assistance of Blue Shield, shall review physicians' fees at least annually to insure that such fees will not remain fixed, but will adjust with the economy."

Recommendations, Reference Committee No. 4

The Report of the Advisory Committee to Blue Shield includes a policy statement which we believe adequately summarizes the position that the House of Delegates should approve with respect to the paid-in-full, usual and customary program for health

insurance. This statement is italized in their printed report on page 18 in the "Reports to the 1969 Session of the House of Delegates," and reads as follows:

"The KMA Board of Trustees has received a communication from the Fayette County Medical Society questioning whether or not the Usual and Customary concept previously adopted in 1968 by the KMA House of Delegates is, in fact, a paid-in-full program.

After reviewing last year's report of the KMA Advisory Committee to Blue Shield and the information disseminated to Kentucky physicians since its approval, it is the opinion of this committee that this does represent a paid-in-full program for covered services.

1. The public is rapidly increasing its demands for paid-in-full type surgical-medical programs which will permit an individual to prepay for the full cost of covered services.

2. It is the official policy of the National Association of Blue Shield Plans that all individual Blue Shield Plans must have available this type of Usual and Customary program.

3. The American Medical Association officially endorses and promotes the Usual and Customary concept for payment of physicians fees by all third parties.

4. Without the paid-in-full concept, Usual and Customary has no meaning other than that of being just a high-priced indemnity program which cannot be sold in the marketplace.

5. In order to make the program operative, certain requirements are necessary. This committee recommends that the Usual and Customary and paid-in-full concept be one and the same with the following requirements recognized:

a. Physicians can signify their support of the Usual and Customary concept by being a 'participating' physician and by signing an agreement to that effect.

b. A physician who does not accept this concept could elect to not sign a participating physician agreement.

c. Participating physicians would agree to accept as payment in full allowances made by Blue Shield's Usual and Customary program for covered services using guidelines established by the KMA Claims Review Committee. Peer review committees, which are a part of these guidelines, will make the final recommendations for reasonable allowances on cases that cannot be processed routinely. Payments will be made direct to the participating physician.

d. Blue Shield's allowances for covered services rendered by non-participating physicians will be determined using the same guidelines as for participating physicians except payment for covered services will be made direct to the subscriber.

6. It is recommended that the KMA Board of Trustees, working in cooperation with Blue Shield, institute an immediate and continuing multi-phasic program of education to assist the profession and the public in the explanation and implementation of the Usual and Customary program.

7. It is further recommended that the Board of Trustees reaffirm the position taken by the 1968 House of Delegates and that it urge the Blue Shield staff to continue marketing the Usual and Customary program under the present guidelines, working toward obtaining individual participating physicians agreements."

The Board of Trustees recommends that the following sentence be added to paragraph 5: "(e) A peer review committee with the assistance of Blue Shield, shall review physicians' fees at least annually to insure that such fees will not remain fixed, but will adjust with the economy." We note that such a review is now being done quarterly by the staff of Blue Shield with quarterly adjustments in the fee schedule, but it would appear advisable to have the said peer review committee appointed as an additional safeguard. Reference Committee No. 4 recommends that this report be adopted and implemented.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded)

A lengthy and thorough discussion ensued, during which both the opponents and supporters of this report spoke. A motion was made, seconded and carried to amend the italicized statement in the reference committee report enumerated paragraph three (3) by adding the following at the end of the sentence: "and that any reference to paid-in-full coverage clearly identify those services which are indeed covered on a paid-in-full basis and also identify the circumstances under which those services must be rendered to all third parties."

The question was called and the original motion as amended carried.

Report of the Advisory Committee to Blue Cross

The Medical Advisory Committee to Blue Cross is composed of seventeen physicians which are appointed from various areas of Kentucky. Representative members of this committee met at the Headquarters Office of Blue Cross-Blue Shield in Louisville to review questionable or controversial claims submitted by physicians that dealt with the need and/or duration of hospital care.

During the eleven months beginning June 1, 1968, through May 1, 1969, the Committee met three times and reviewed twenty cases, amounting to 558 hospital days. Of this amount, 126 days were disallowed, representing a saving to Blue Cross of approximately $5,600.00. In addition, it is estimated that approximately $690.00 in savings has accrued to Blue Shield on these cases. It is interesting to note that during the same period, 114 cases were reviewed by local review committees, amounting to a total of 1,657 hospital days, of which 59 were disallowed, for a saving of approximately $2,600 to Blue Cross and $322.00 to Blue Shield.

By continuously monitoring the Blue Cross Plan, the committee serves the dual purpose of furnishing the public and the medical profession with the most advantageous coverage possible for the premiums paid, while at the same time, avoiding abuses to Blue Cross by studying and correcting trends before they become abuses and striving to keep physicians in the state informed and interested in the operation of Blue Cross.

The members of this committee are to be congratulated for their assiduity, dedication and loyalty. Not only is their work educational to the other physicians in the state, but by accepting the responsibility of this committee's work, they demonstrate that the Kentucky Medical Association and Blue Cross are making an honest effort to screen hospitalization and to keep down unnecessary or prolonged hospital stays by patients.

Our entire committee usually meets once a year in conjunction with representatives from Blue Cross to discuss the work of the committee, and to make constructive recommendations to Blue Cross.

George W. Pedigo, M.D., Chairman

Recommendations, Reference Committee No. 4

The report of the Advisory Committee to Blue Cross indicates a satisfactory operation of claims review during the past year. By continuously monitoring the Blue Cross Plan, the committee serves to furnish the public and medical profession with the most advantageous coverage possible for the pre-

miums paid, while at the same time avoiding abuses to Blue Cross. Reference Committee No. 4 recommends that this report be adopted.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Senior Day Committee

Your Senior Day Committee met this year and completely redesigned the format of the KMA Senior Day Program. Senior Day, this year, featured a joint session for the Senior Medical Students of both the University of Louisville and the University of Kentucky, and was held on March 17 at the Executive Inn, Louisville. The committee plans to hold next year's joint session in Lexington.

The length of the entire program was shortened considerably, with the afternoon sessions featuring short presentations on "Features of Organized Medicine", "Medical Ethics and Courtesies", "Medical Records and Malpractice" and "Medical Legislation and Politics". Following these presentations, the seniors were divided into four discussion groups with the guest speakers rotating to each group at 15 minute intervals.

The evening session of the program featured the Reverend William Slider, Louisville. The Jefferson County Medical Society hosted the evening session, and attendance this year was exceptional.

As in the past, kits of materials were distributed to each student to help narrow the communications gap that is always with us. It is hoped that these programs will be of some help to them, and will serve as an influence to keep them alert, interested and responsive to correspondence, programs and other informational services always readily available from the county, state and national medical groups.

We strongly encourage the continuation of this program with the usual full planning sessions as held in the past.

The committee is grateful to the State Medical Association, House of Delegates and the Board of Trustees for their help in making it possible for us to serve in this capacity. Appreciation is also extended to the KMA members and guests who participated, the University of Louisville School of Medicine, University of Kentucky College of Medicine and the Jefferson and Fayette County Medical Societies.

As Chairman, I would also like to thank the members of the committee: John Bishop, M.D., Eugene H. Conner, M.D., David H. Hull, M.D., Robert Johnson, M.D., Max Irvin, M.D., and Jacqueline Noonan, M.D., for their excellent cooperation in the preparation of this program.

Hoyt D. Gardner, M.D., Chairman

Recommendations, Reference Committee No. 4

The report of the Senior Day Committee describes a very successful program held on March 17 in Louisville for the senior students of both the University of Louisville and University of Kentucky medical schools, employing lecturers, discussion groups, and kits of information concerning features of organized medicine, ethics, malpractice, records, legislation and politics. The report recommends continuance of the program with next year's meeting to be held in Lexington. Reference Committee No. 4 recommends that this report be adopted and implemented.

Mr. Speaker, I move adoption and implementation of this section of the report.

(Seconded; carried)

Report of the Committee on School Health, Physical Education and Medical Aspects of Sports

The Committee on School Health, Physical Education and Medical Aspects of Sports met three times this Associational year, on January 23, April 3, and June 12. As the committee was recently expanded to 15 members, we now enjoy representation in each KMA Trustee District. The committee members have expressed a keen interest in the work and goals of this committee and have demonstrated a desire and willingness to work toward the realization of these goals.

We continue our strong interest in seeing school health committees activated at the county society level, and urge each county medical society to appoint such committees next year with a request that the chairman's name be submitted to the KMA Headquarters Office.

Henry B. Asman, M.D., KMA President, has been most cooperative with our committee this year by urging physician attendance at high school athletic events in their community in his visits to the KMA Trustee District meetings. He also sent a letter to all county society presidents which had no designated school health chairman, urging them to appoint one and forward his name to the Headquarters Office.

Again this year, the committee was privileged to have the opportunity to present an exhibit at the 1969 Annual Meeting of the Kentucky Education Association in Louisville last April. Since the interests of the committee have expanded so much, we felt it appropriate to design our own exhibit around drug abuse, sex education and physical education. We were most grateful to Mr. Richard L. Ross and other members of the Jefferson County Academy of Pharmacy for their cooperation during this meeting in helping to staff the booth. We are of the opinion that this was one of the better exhibits presented by our committee at the KEA Convention.

We also presented an exhibit on the same topic during the Health Education Workshop which was held from July 6 through August 1 at Western Kentucky University in Bowling Green. Committee member, Vaughn Lee Fisher, M.D., was very helpful in this project and appeared on the workshop program.

Since our committee membership represents all sections of the state, we had a thorough discussion concerning school health activities, physical education and medical aspects of sports being implemented at the local level.

As a result of this, the committee has developed a set of guidelines to aid each local committee in establishing a sound school health program at the local level. Hopefully, this will also create a stronger liaison with our own committee at the state level. In addition, our committee and KMA will be represented next month at the Twelth National Conference on Physicians and Schools in Chicago.

This committee also requested, and was granted permission, to present a 75 minute presentation on School Health, Physical Education and the Medical Aspects of Sports during the General Scientific Session of the 1969 KMA Annual Meeting. This presentation will be on Thursday morning, September 25, at 10:45 a.m., and we urge all members of the House to attend.

The committee members noted the increasing amount of federal money available to the school systems and have devoted special attention to the Headstart Programs and Title I funds.

The Title I program now authorizes in excess of $8 million which can be spent in Kentucky by school officials without medical guidance. There is a

strong need for participation of physicians at the local level to help channel Title I funds so that they will be utilized more effectively for health care. With medical guidance, these funds could be used for such purposes as school examinations, preventive medicine, immunization, etc. We must get involved at the county level and our committee urges that committees be established at the local county society level to give proper medical guidance to Title I and other such medical programs spending funds on medical services.

We are continuing our liaison with the Kentucky Department of Education and other statewide groups that have a particular interest in the health of our school-age children.

O. B. Murphy, M.D., Chairman

Recommendations, Reference Committee No. 4

The Committee on School Health, Physical Education and Medical Aspects of Sports has encouraged the establishment of school health committees at the county society level and has set up guidelines for a sound school health program. The committee urges these local county society committees to give proper medical guidance to the use of Title I and other such funds available for use by school officials for medical programs. Reference Committee No. 4 recommends that this report be adopted and implemented.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded and carried)

Report of the Advisory Committee to Woman's Auxiliary

The KMA Advisory Committee to the Woman's Auxiliary has not found it necessary to meet this Associational year. However, we remain available for consultation.

We are of the opinion that the committee can be a very helpful one, and should be continued.

George W. Pedigo, M.D., Chairman

Recommendations, Reference Committee No. 4

The report of the Advisory Committee to Woman's Auxiliary was reviewed.

Mr. Speaker, I move the acceptance of this section of the report.

(Seconded; carried)

Report of the Ad Hoc Study Committee for Improved Community Health

This committee's established purpose was to assist local county societies in establishing committees of both physicians and non-physicians to study their community health situation and to assist such committees in any way possible by research information and information concerning possible grant assistance, etc., so that those committees could work toward the improvement of their own local situation.

During the previous fiscal year, the committee had received the approval of the Hardin County Medical Society and of the physicians in Owen County to agree to attempt the establishment of local committees to carry out the purpose of this committee. With the excellent cooperation of the Department of Community Medicine at the University of Kentucky, students were again assigned to survey these two counties. Following this, meetings of the committee were held in the respective counties.

On December 4, 1968, the majority of the committee went to Elizabethtown, Kentucky, for a meeting at the Hardin Memorial Hospital. They met with Doctors Bernard Greenwell, Thomas J. Ferriell, Jr., and David Lewis of the Hardin County Medical Society; Robert Kane, M.D., of the Department of Community Medicine, University of Kentucky; and Mr. Applegate and Mrs. Murphy of the KMA staff. Doctor Greenwell had made a careful study of the problems of Hardin County and reported on these. This, the reports of the other physicians and the student's report, were discussed thoroughly. As a result, the physicians of Hardin County felt that they would attempt to form the local committee required. However, when it actually came down to doing this, it was found that the same non-physicians that they would have liked to have had on the committee were already selected for the regional committee for comprehensive health planning and that it was not practical to form another committee with the same people.

On January 15, 1969, the ad hoc committee met at the Smith House in Owenton, Kentucky; unfortunately, only the chairman and Doctor Dudderar were able to be present to meet with Doctor Maurice Bowling and Doctor Oscar Cull, (representing 100% of the physicians in Owenton) and Doctor Kane of the Department of Community Medicine of the University of Kentucky. KMA staff was represented by Mr. Applegate. The problems of Owen County were gone into in detail and both local physicians were of the opinion that a local committee for improved community health would be beneficial, but to this date (June 12), the committee has never been formed.

It is, therefore, the opinion of the Ad Hoc Study Committee for Improved Community Health that although the purpose for which it was established by KMA was a most worthy one, so much of the work of the committee overlapped the Comprehensive Health Planning Committee established by the state, under federal assistance, that it was practically impossible for the physicians in these counties, or any other counties we might have selected, to establish the type of committee desired. We, therefore, recommend to KMA that this committee not be continued in future years.

We would recommend instead, therefore, that KMA recommend to its constituent societies that they take an active part in the formation of the Comprehensive Health Planning Councils in their respective regions.

The chairman would like to express his appreciation to the committee members, Donald K. Dudderar, M.D., Newport; Earl P. Oliver, M.D., Scottsville; Nicholas J. Pisacano, M.D., Lexington; Fred C. Rainey, M.D., Elizabethtown and Russell E. Teague, M.D., Frankfort.

Irving F. Kanner, M.D., Chairman

Recommendations, Reference Committee No. 4

The report of the Ad Hoc Study Committee for Improved Community Health indicates that the functions planned for this committee overlap the functions already assumed by the Comprehensive Health Planning Councils established by the state under federal assistance. It is recommended that the Kentucky Medical Association recommend to its constituent societies that they take an active part in the formation of the Comprehensive Health Planning Councils in their respective regions. Reference Committee No. 4 recommends that this report be adopted and implemented.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded; carried)

Report of the Ad Hoc Committee on Insurance Forms

The Ad Hoc Committee on Insurance Forms was appointed this year for the specific purpose of implementing Resolution F adopted by the 1968 session of the House of Delegates.

Resolution F requested that KMA work with the appropriate department of state government and with insurance companies to modify the procedure whereby some insurance policies require weekly forms to be completed by the physician. It was felt that such a weekly requirement is unnecessary and that a just and realistic program could be developed.

Your committee met with representatives of the Health Insurance Council and representatives of insurance companies selling such policies at which time a full discussion was held concerning this matter.

Your committee then submitted a report to the Board of Trustees in March of this year. To eliminate the requirement of completing weekly forms, a letter is being submitted to the Health Insurance Council stating KMA's position in this regard. It will be pointed out that one report at the end of an acute illness, and second, that a monthly or six-week report should meet an insurance company's needs in chronic illness cases.

David M. Cox, M.D., Chairman

Recommendations, Reference Committee No. 4

The Ad Hoc Committee on Insurance Forms (included in the report of the Chairman, Board of Trustees) has submitted a letter to the Health Insurance Council pointing out that one report at the end of an acute illness and monthly or six week reports during a chronic illness should meet the needs of insurance companies rather than that weekly reports be required. Reference Committee No. 4 recommends that this report be adopted.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Resolution C

John F. Berry, Jr., M.D., Delegate, Fayette County Medical Society

WHEREAS, medical diagnosis is an integral part of the practice of medicine and diagnostic services are physicians' services, and

WHEREAS, the provision of so called "pre-admission testing" by Blue Cross Plans involves provision of diagnostic medical services to ambulatory patients, and

WHEREAS, provision of pre-admission testing under hospital care insurance limits the site of service to the hospital and payment for this service to the hospital, and

WHEREAS, these restrictions inhibit attending physicians in selecting where and to whom to refer patients for these medical services, and

WHEREAS, these restrictions discriminate against the independent practice of radiology by physicians in offices and in hospitals, and

WHEREAS, the insurance of medical benefits is the purpose of Blue Shield Plans and commercial medical care insurers, and

WHEREAS, provision of insured ambulatory diagnostic benefits eliminates some medically unnecessary occupancy of hosptial beds, and

WHEREAS, ambulatory diagnostic benefits are desired by patients, have been recommended by spokesmen for government, labor and management, and will be made available through pre-payment, and

WHEREAS, this resolution has been approved by the Kentucky Chapter, American College of Radiology, therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association requests and urges Blue Shield Plans and other insurers of physicians' services in Kentucky to aggresively extend provision of ambulatory benefits to those insured, and be it further

RESOLVED, that the Kentucky Medical Association notes that provision of ambulatory diagnostic benefits by Blue Cross and insurers of hospitalization restricts patients and physicians in freely selecting where these medical services will be accomplished and by whom.

Recommendations, Reference Committee No. 4

Resolution C, Insured Ambulatory Diagnostic Benefits which was introduced by John Berry, delegate of the Fayette County Medical Society, was reviewed. The Reference Committee recommends adoption of Resolution C.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Resolution D

Fayette County Medical Society

WHEREAS, Kentucky Physicians Mutual has purported through its advertisements in both lay and professional areas to be a non-profit organization governed by Kentucky physicians, and

WHEREAS, in point of fact, Kentucky Physicians Mutual is a private corporation accountable only in so far as any other company is under appropriate Kentucky law, and

WHEREAS, the Board of Directors of Kentucky Physicians Mutual, although composed of 75 per cent physicians, is self-perpetuating with the nature of the organization precluding rapid modification in membership and

WHEREAS, in terms of physician directors, the number is hardly enough to be representative of the total physician population in Kentucky and thus cannot be responsive to changes in attitudes among Kentucky physicians, and

WHEREAS, the Advisory Committee to Blue Shield of the Kentucky Medical Association is the only focal body of the Kentucky Medical Association with influence upon Kentucky Physicians Mutual, therefore be it

RESOLVED, that Kentucky Physicians Mutual become more responsive to a broader segment of organized medicine through whatever mechanism its corporate entity decides, and be it further

RESOLVED, that the Advisory Committee of Kentucky Medical Association to Blue Shield be modified to permit better physician representation by geographic area and specialty, preferably by local election in some representative fashion.

Recommendations, Reference Committee No. 4

Resolution D, Kentucky Physicians Mutual "A" was introduced by the Fayette County Medical Society. This resolution deals with the composition of the Advisory Committee of KMA to Blue Shield and recommends modifications in its method of appointment. The Reference Committee recommends this resolution not be adopted on the grounds that adequate representation can be obtained under the present method of appointment as stipulated in the Constitution and Bylaws of the KMA, Chapter VIII.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded)

A motion was made and seconded that the following resolution be substituted for the motion before the House:

"RESOLVED: that the Kentucky Medical Association Advisory Committee to Blue Shield be structured to protect the interest of the members of KMA and that members of the Board of Directors of Kentucky Blue Shield not be permitted to serve on this committee but be encouraged to attend meetings of the Advisory Committee as a source of information and be it further

"RESOLVED: that the members of the Advisory Committee be selected so as to afford the fairest and most equitable representation of the various facets of the medical profession in Kentucky."

After brief discussion, the following amendment was moved, seconded, and passed: that the words "no more than two" be inserted in the first Resolve following the words "members of KMA and that" and further that the word "not" following the words "Kentucky Blue Shield" be deleted.

The original substitute motion as amended carried, and reads in its entirety as follows:

"RESOLVED, that the Kentucky Medical Association Advisory Committee to Blue Shield be structured to protect the interests of the members of KMA and that no more than two members of the Board of Directors of Kentucky Blue Shield be permitted to serve on this committee, but be encouraged to attend meetings of the Advisory Committee as a source of information, and be it further

"RESOLVED, that the members of the Advisory Committee be selected so as to afford the fairest and most equitable representation of the various facets of the medical profession in Kentucky."

Resolution E

Fayette County Medical Society

WHEREAS, the House of Delegates did not vote upon a paid-in-full Blue Shield plan in 1968, but rather a usual and customary plan, and

WHEREAS, neither the House of Delegates nor the membership of Kentucky Medical Association realized that Kentucky Physicians Mutual held the two terms to be synonymous, therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association, the Advisory Committee to Kentucky Physicians Mutual, and any other Kentucky Medical Association committee with interest in this area be requested to reconsider the entire question of usual and customary/paid-in-full contracts currently sold by Kentucky Physicians Mutual.

Recommendations, Reference Committee No. 4

Resolution E, Kentucky Physicians Mutual "B" was introduced by the Fayette County Medical Society. This resolution calls for reconsideration of the entire question of Usual and Customary and paid-in-full contracts currently sold by Kentucky Physicians Mutual.

The Reference Committee feels that the statement of policy included in Report No. 22, Advisory Committee to Blue Shield is an adequate statement of the KMA position on this subject, and that if Report No. 22 is adopted, Resolution E would be out of order. Reference Committee No. 4 recommends that Resolution E not be adopted.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Resolution H

Fayette County Medical Society

WHEREAS, at the June 10, 1969, meeting of the Fayette County Medical Society displeasure was expressed with the Kentucky Physicians Mutual, Inc., therefore, be it

RESOLVED that the Fayette County Medical Society go on record as being actively opposed to the "paid-in-full" Kentucky Physicians Mutual plan recently approved by the House of Delegates of the Kentucky Medical Association, and be it further

RESOLVED that Kentucky Physicians Mutual be urgently requested to suspend immediately all proffers of such contracts to their prospective customers who may be planning to apply for medical care in Fayette County.

Recommendations, Reference Committee No. 4

Resolution H, Kentucky Physicians Mutual "C" was introduced by the Fayette County Medical Society. This resolution appears to apply to action taken by Fayette County Medical Society with respect to its own situation, and the Reference Committee questions whether action by KMA is called for. In any event, the intent of the second resolve is contrary to the policy statement found in Report No. 22, Advisory Committee to Blue Shield. Reference Committee No. 4 recommends that Resolution H not be adopted.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Resolution L

E. B. Schoenbachler, M.D., Delegate, Jefferson County Medical Society

WHEREAS, the definition of "customary" as proposed and approved by the KMA Claims Review Committee and also approved by the KMA Board of Trustees is as follows:

Customary—A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socie-economic area), and

WHEREAS, such a definition would infer and encourage dual or variable fee allowances based on unfair criteria such as Board status or limited geographical areas, and

WHEREAS, a similar resolution was passed by the House of Delegates of the Kentucky Academy of General Practice,

THEREFORE, BE IT RESOLVED that the House of Delegates of the Kentucky Medical Association directs that the definition which follows and all other guidelines shall be designed to safeguard against dual fee schedules under all insurance programs including Medicare and Medicaid, and

BE IT FURTHER RESOLVED that the previous definition shall be substituted by the following:

Customary—A fee is "customary" when it is within the range of usual fees charged for the same service by a physician qualified to perform that service within the general area from which he practices (To include at least one entire county area—or additional counties or proximal portions of adjacent counties—so as to include the range of fees for fifty or more practicing physicians, regardless of specialty).

Recommendations, Reference Committee No. 4

Resolution L, Usual, Customary and Reasonable Fees was introduced by E. B. Schoenbachler, M.D.,

Delegate of the Jefferson County Medical Society. This resolution proposes a change in the definition of "customary fee." The Reference Committee feels that the presently accepted definition quoted in the first portion of the resolution is acceptable and widely recognized, conforming to the definition of the American Medical Association, and that the change proposed would result in considerable confusion with no significant advantages gained. Reference Committee No. 4 recommends that Resolution L not be adopted.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 4 as a whole as amended.

(Seconded and carried)

I wish to thank Mrs. Ladonne Patterson, Doctor John Hill, Somerset; Doctor Hugh Houston, Murray; Doctor Robert Houston, Eminence, and Doctor Thomas L. Heavern, Highland Heights, for their time and help on this committee.

REFERENCE COMMITTEE NO. 4
Edward N. Maxwell, M.D., Louisville, Chairman
John Hill, M.D., Somerset
Hugh Houston, M.D., Murray
Robert Houston, M.D., Eminence
Thomas L. Heavern, M.D., Highland Heights

REFERENCE COMMITTEE NO. 5

Paul J. Parks, M.D., Bowling Green, Chairman

Reference Committee No. 5 considered the following reports:

26. Report of the Advisory Committee to Selective Service
39. Report of the Coordinating Commission on Governmental Medical Services
40. Report of the Technical Advisory Committee on Physician Services (Title XIX)
41. Report of the Advisory Committee on Title XVIII
42. Report of the Claims Review Committee
43. Report of the Committee on Appalachian and OEO Programs

Resolution K—Drug Combinations-FDA (E. B. Schoenbachler, M.D., Delegate, Jefferson County)

Report of the Advisory Committee to Selective Service

The purpose of this committee is to try to maintain a proper balance between the distribution of medical care to the citizens of the state and to the Armed Forces.

Call No. 44 from National Selective Service Headquarters, Washington, D.C., was made January 23, 1969 for 437 physicians from the entire nation. This call was subsequently reduced to 246 physicians (233 Doctors of Medicine and 13 Doctors of Osteopathy).

Your committe met at KMA Headquarters Office on February 26, 1969, and considered a total of 55 Kentucky physicians, making appropriate recommendations to Kentucky State Selective Service Headquarters on each case.

In accordance with recommendations of Reference Committee No. 5, and approved by KMA Executive Committee on October 31, 1968, Selective Service Headquarters was requested to expedite reports to each physician considered by the committee. We were assured by Colonel Taylor Davidson and his staff that each physician would be notified at once.

Your committee then discussed Resolution No. 37 "Military Deferment for General Practice", and unanimously adopted a general policy of deferment for physicians who expressed a desire and actually located for practice in an area of critical physician shortage, as defined by KMA and the Rural Scholarship Fund. This policy has already resulted in one or more physicians locating in such areas.

To date, no appeals have been received, but several inquiries have been made requesting information concerning critical areas.

The committee members have been most cooperative and helpful. Excellent and efficient support has been rendered by KMA Headquarters staff members.

Colonel Taylor Davidson and his Headquarters Staff at Kentucky Selective Service have been most cooperative in all phases of the committee work.

In case of additional activities by the committee, these will be reported at a later date as an addendum to this report.

As chairman of the committee, I will plan to appear before the appropriate Reference Committee to answer questions which may arise.

It has been a pleasure to work with the committee and to serve the Association.

Glenn U. Dorroh, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Advisory Committee to Selective Service, and Glenn U. Dorroh, M.D., the Chairman of this committee, was there to discuss it. He and his committee are happy with their relationship with the State Selective Service Headquarters and the National Selective Service Headquarters. They have apparently been working well together, and the Kentucky Medical Association commends them for this cooperation.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Coordinating Commission on Governmental Medical Services

The various committees of the Commission have had one or more meetings this year, and some of them have spent a great deal of time in evaluating the various programs dealing with the government as a third party in medicine. Our new committee (Claims Review) has been appointed since the last House of Delegates meeting and is functioning. Each of the committees has made its report to this House of Delegates, and each member is to be highly complimented for his work throughout the year.

The Appalachian and OEO Programs seem to have adequate physician supervision and are making some progress in ministering to those who perhaps were not receiving adequate medical care from private medicine.

The Claims Review Committee is now fully organized at the state level and has begun to work. A few committees are functioning on local levels. The solution of problems regarding unusual fees is a function of this committee.

The Committee on Medical Education is orienting its study in the area of continuing education of

physicians, as it is believed the KMA has requested. The proposal that some of this be done at the local hospital level is, we believe, a good one.

The Advisory Committee on Title XVIII has been involved in evaluating physician's proper utilization of the Medicare Program and has made the suggestion that HEW inform the public better about what Medicare actually does provide and, perhaps more importantly, what it does not provide. Kentucky physicians are reminded that they should be very careful that they do not over-utilize the Medicare Program.

The Technical Advisory Committee on Physician Services (Title XIX) is still having a very difficult time advising the State Medicaid Program concerning fees. It has made some suggestions for reducing certain services in order to stay within the budget and has questioned the utilization of the program by some physicians in the state. This is a continuingly very difficult area, and the committee is to be highly commended for its long hours, not only in its own individual work, but in meeting with the Frankfort officials to advise concerning problems with the program.

Paul J. Parks, M.D., Chairman

BOARD ACTION: Approved with the notation that physicians should feel free to use the KMA Claims Review Committee mechanism.

Recommendations, Reference Committee No. 5

The reference committee heard the report of the Coordinating Commission on Governmental Medical Services that succinctly reviewed the reports of its daughter committees, and we accept the report as written.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Technical Advisory Committee on Physician Services (Title XIX)

This has been a busy year for all members of the quasi-governmental Technical Advisory Committee on Physician Services (Title XIX). There were nine scheduled committee meetings and five meetings of the Advisory Council for Medical Assistance, which were also attended by committee members. Once again there was approximately 100 percent attendance at all meetings. Representatives of the Kentucky State Department of Economic Security and of the Medical Assistance Division of the Kentucky State Department of Health have attended our committee meetings.

The commitee has continued to request the payment of physicians' usual and customary fees for in-hospital services as previously reported. We have been told, however, that unless a special session of the legislature is convened, this would be impossible to attain until the 1970 session of the Kentucky General Assembly. The committee will continue to emphasize the fairness of compensation for in-hospital service coverage.

The committee has expressed dissatisfaction with the present handling of the usual and customary concept for out-of-hospital services in that many physicians' usual and customary billing charges were returned unpaid with the statement that they were not within the range. The committee advocated that the state pay its reasonable limitation to these physicians instead of demanding the physician renegotiate a rate lower than his normal charge to other patients.

The Commissioners of Finance and Economic Security, in cooperation with Governor Louie B. Nunn and the officers of the Kentucky Medical Association and dealing directly and not through our committee, instituted a rapid payment system which should eliminate complaints of delay in payment. However, this is turn may create some difficulties in the keeping of office records for the Internal Revenue Service and other purposes in that the present practice is a lump sum monthly payment without itemization of accounts.

The committee has made a number of suggestions in the program to assist in a better control of possible over-utilization of the program by both patients and providers of service.

Clyde C. Sparks, M.D., of Ashland, was appointed by Governor Louie B. Nunn to serve on the Advisory Council for Medical Assistance. E. C. Seeley, M.D., of London, is the Chairman of the Formulary Subcommittee of the Advisory Council. Harold Morris, M.D., of Louisville, is the other physician member of this subcommittee which is composed of representatives of dentistry, hospitals, medicine and pharmacy.

Title XIX is facing financial problems nationally in most states, including Kentucky. Meetings have been held with the Technical Advisory Committees of all providers of services at which time the budgetary problems were outlined in detail. Accordingly, a number of suggestions have been submitted to the program in Kentucky to help control utilization and expenditures.

The Physicians' Advisory Committee has discussed possible ways of controlling expenses. Of the possible selections, it was deemed best by the committee that there be a limit of two initial visits or complete physician examinations allowed per patient per physician per year. In addition, there would be a charge limitation of three persons in one family being seen by one physician in one day. It is possible that these two items may save many thousands of dollars without basically altering the usual and customary out-of-hospital care of patients.

A number of other controls are also being implemented. Recipients are being issued a medical history card to help control patient over-utilization. Physicians and pharmacists indicate on the medical history card each time the patients receive service.

The Kentucky Medical Assistance Program staff has distributed to the committee a copy of a proposed medical review committee structure. It was suggested that the duties would be initially to concentrate on reviewing physician utilization on a broader scale than the Technical Advisory Committee on Physician Services could do. It was pointed out, however, that the responsibilities of the committees may expand from utilization review and quality control activities as the program coverage increases. The chairman of the Advisory Council for Medical Assistance has asked that recommendations be made at the September, 1969 quarterly meeting of the Advisory Council to develop administrative procedures in the utilization of the program. The committee has recommended to the council and the KMA Board of Trustees that physician utilization committees and their structure should be developed by KMA with the thought in mind that the committees could be the mechanism to serve all governmental and third party carriers. The state proposal involved a metropolitan, urban and rural committee concept. The establishment of 15 regional out-of-hospital utilization review committees has been an alternate suggestion.

There are many unsolved problems in operating a $50,000,000 annual program attempting to cover the medical needs of 270,000 people. This committee has offered advice after hard work and long hours of deliberation. Some of the advice has been accepted, some has not. This is only an interim report on some of the activities of the committee.

There can be no final report. By the time a report is submitted, there will be a new crisis or problem in addition to unresolved ones.

As chairman, I wish to thank the dedicated members of this committee who have worked so diligently in the interest of an improved Medicaid Program in Kentucky. The work of this committee has been truly a team effort and reflects very active advice and support by each member.

Carroll H. Robie, Jr., M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed at length the report of the Technical Advisory Committee on Physician Services (Title XIX) and a full discussion by its chairman and the President of KMA, as well as other interested delegates. The committee reiterates that portion of the report urging the State to pay to its reasonable limitation usual and customary fees for out-of-hospital services under Title XIX.

The committee takes cognizance of Paragraph eight in that there might be limitations of day-visit-patient charges and agrees in principle with necessary limitations to curb physician and patient over-utilization.

This committee favors legislative changes in Title XIX to initiate token fees for physician and pharmacy services to help curb patient over-utilization.

It was called to the attention of the reference committee that utilization review for physicians' services has been discussed by the Title XIX Committee and the Board of Trustees. It is our recommendation that the House of Delegates instruct the Board of Trustees to proceed with haste in the development of such a mechanism.

It is recognized by this committee that previous recommendations have been made to the Medical Assistance Program that have not been implemented; specifically, the recommendation of last year's House of Delegates that glaucoma medications be added to the approved Medicaid drug list. We request that this be implemented.

The Title XIX Committee is to be commended for continually trying to obtain usual and customary fees for all services although we realize this cannot be accomplished until the Commonwealth assumes its fiscal responsibilities.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded)

During the discussion, a motion was made to amend the reference committee report by adding the words "by patients" after the words "token fees" in the third paragraph. This amendment was accepted by the reference committee chairman. The sentence would now read: "This committee favors legislative changes in Title XIX to initiate token fees by patients for physician and pharmacy services to help curb patient over-utilization."

A second amendment to the reference committee report was moved, seconded, and passed as follows: That in the first paragraph, second sentence, the words "to its reasonable limitation usual and customary fees" be deleted and the following words substituted therefor: "its reasonable limitation to those physicians whose charges are not within the allowable range, rather than demanding the physician to negotiate a rate lower than his normal charge to other patients". The sentence as amended reads: "The committee reiterates that portion of the report urging the state to pay its reasonable limitations to those physicians whose charges are not within the allowable range, rather than demanding the physician to negotiate a rate lower than his normal charge to other patients for out-of-hospital services under Title XIX."

The original motion as amended then passed.

Report of the Advisory Committee on Title XVIII

The committee held two meetings during the year and the chairman examined multiple reports regarding Medicare. The program in Kentucky seems to be running fairly smoothly, but there are two areas that seem to the committee to need improvement.

The first involves the apparent lack of information disseminated to the public regarding the purpose of Medicare and what it actually provides. It appears to this committee that the public has been led to believe that this program covers many more services than it actually does and when the public learns otherwise, there is pressure on review committees and individual physicians to seek coverage for unauthorized services, especially in the area of extended care facilities.

The second problem is that of overutilization by both physicians and patients. After review of numerous claims, including a day spent at the Metropolitan headquarters in Lexington, it is the committee's opinion that there is mutual overutilization of the program by a few patients and physicians. According to information given on these reviewed records, the committee feels some physicians are responding to patient requests with overly frequent visitations and in some instances, over treatment, particularly in respect to injectibles as well as perhaps also in the use of laboratory procedures.

It appears to this committee that perhaps some statement of resolution should come from the House of Delegates to all physicians in the Association to be sure that services to Medicare recipients are not above and beyond those of patients not covered by Medicare.

It is also the committee's feeling that the apparent overutilization would have one of two inevitable effects:

a. Either the KMA will be forced to police individual physician members, or

b. A nonmedical organization (third party) will be involved in this policing action.

The committee believes the policing action, if such is needed, should be done by KMA and the necessary mechanism be set up to do so, if indeed it is not already present in the organization.

Paul J. Parks, M.D., Chairman

Recommendations, Reference Committee No. 5

The reference committee discussed the Report of the Advisory Committee on Title XVIII and recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded)

In the discussion of this report, a motion was made to amend the reference committee report by quoting the wording in the last two paragraphs of the Report of the Advisory Committee on Title XVIII as a part of the reference committee report, as follows:

"It is also the committee's feeling that the apparent over-utilization would have one of two inevitable effects:

"a. Either the KMA will be forced to police individual physician members, or

"b. A nonmedical organization (third party) will be involved in this policing action.

"The committee believes the policing action, if such is needed, should be done by KMA and the necessary mechanism be set up to do so, if indeed it is not already present in the organization." The amendment was seconded and carried.

The original motion as amended was then adopted.

Report of the Claims Review Committee

This is the first Annual Report of this new committee. In implementing the resolution of the KMA Advisory Committee to Blue Shield, the 1968 KMA House of Delegates voted that the Board of Trustees appoint a KMA Claims Review Committee. When this committee was selected, provisions were made so that the geographic areas of the state and the respective fields of practice would have representation. The purpose of this committee is to review claims submitted to it by county societies, physicians, Blue Shield and all third parties.

The resolution encouraged all county medical societies with 20 or more active practicing physician members to establish local review committees, and that counties having between 10 and 20 physicians be invited to establish their own review committees.

This was primarily an organizational year for both the state and county committees. A number of counties have already formed committees and are meeting regularly. A number of other counties are in the process of forming committees.

Your KMA Committee met for the first time on November 21, 1968, and since this time there have been additional meetings of the Claims Review Executive Committee.

Our first concern was to establish guidelines for administering health care programs based on usual and customary fees. These guidelines were approved by the KMA Board of Trustees at their December, 1968, meeting.

Throughout the Associational year an effort has been made to acquaint all the physicians of the state with the activities of the committee. In November of 1968 our president wrote to all KMA members explaining the claims review merchanism and enclosed with the letter a copy of the 1968 resolution. There have also been a number of articles in the KMA Journal. The "Insurance Page" of the KMA Journal for both December, 1968, and March, 1969, were devoted to claims review and the usual and customary approach. In the February issue of the KMA Journal there was published a special article entitled, "Usual and Customary Guidelines Approved."

By computer technique Blue Shield is constantly reviewing its charges so that it is not necessary for a physician to notify them of a change in fee. Current information is updated when a claim is received from a physician.

Working within these guidelines, the committee members are attempting to serve the profession and the individual physician to the best of our ability. As of this writing, we have reviewed 29 claims submitted to us by all third parties with the usual and customary programs in Kentucky.

It is suggested this be a continuous committee with one third of the members replaced each year so that no member would serve more than three successive years. It is also suggested that there be a new chairman and a vice-chairman each year with the vice-chairman of the previous year becoming the new chairman.

Roy H. Moore, Jr., M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 evaluated the Claims Review Committee report and believes the committee is to be highly commended by this Association for the difficult, but necessary task it has to do. We concur in the desire of the committee, as expressed in the last paragraph of its report, that it be a continuous committee with one-third of the members replaced each year so that no member would serve more than three successive years.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded and carried)

Report of the Committee on Appalachian and OEO Programs

The Committee on Appalachian and OEO Programs met twice during the Associational Year. At the November 21, 1969, meeting, the committee members met with Harvey Sloane, M.D., Director of the Park DuValle Neighborhood Health Center in Louisville and toured the clinic buildings which were then under construction.

At the second meeting of the committee held February 20, 1969, Mary Fox, M.D., of Hyden, and Russell Hall, M.D., Prestonsburg, Directors of the two OEO Programs in Eastern Kentucky, were invited to make reports on the programs in their areas.

Two members of the Committee on Appalachian and OEO Programs are active participants in the Appalachian Regional Health project and reported at the meeting on the progress in their areas.

The committee obtained written reports from the Directors of each of the OEO Health Programs in Kentucky for publication in the KMA Journal.

The committee members were interested in the diversity of approaches these various programs are taking and feel that KMA should continue to keep in close contact to observe their direction in the future.

Frank M. Gaines, Jr., M.D., Chairman

Recommendations, Reference Committee No. 5

The report of the Committee on Appalachian and OEO Programs was reviewed and accepted as filed.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Resolution K

E. B. Schoenbachler, M.D., Delegate, Jefferson County Medical Society

WHEREAS, recent efforts by the Food and Drug Administration have been made to prohibit the manufacture and sale of antibiotic-drug combination products such as Panalba, Mysteclin-F etc., and

WHEREAS, these have been marketed and used with efficacy and reasonable safety as prescribed by qualified physicians. In actual clinical practice they are used to treat individual patients with specific and sometimes non-specific illnesses, often to prevent super-infections by fungi, etc., and

WHEREAS, the prohibition of such products would unnecessarily interfere with the private practice of medicine, and

WHEREAS, a similar resolution was passed by the House of Delegates of the Kentucky Academy of General Practice,

THEREFORE BE IT RESOLVED that the House of Delegates of the Kentucky Medical Association strongly urges that the Food and Drug Administration refrain from actions to prohibit the manufacture

and sale of useful and reasonably safe combination products, and

BE IT FURTHER RESOLVED that the issuance of drug warnings and information on drugs shall be the appropriate duty of FDA but that these shall likewise be considerate of the actual clinical practice of private medicine as well as research and academic factors, and

BE IT FURTHER RESOLVED that copies of this resolution be disseminated to the appropriate federal agencies and to the American and other state medical associations as well as the press.

Recommendations, Reference Committee No. 5

Resolution K, Drug Combinations-FDA, introduced by E. B. Schoenbachler, M.D., Delegate of the Jefferson County Medical Society, was reviewed, and the committee recommends that Resolution K not be adopted because it serves as an effective endorsement for specific drugs and remands the FDA for actions they have not taken.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded)

There was a brief discussion concerning the resolution as presented and the fact that the reference committee recommended it not be adopted. Then, a motion was made to amend the original motion with the following substitute resolution:

WHEREAS, many combination drugs have been marketed and used with efficacy and reasonable safety as prescribed by qualified physicians, and

WHEREAS, the prohibition of such products unnecessarily interferes with the practice of medicine, therefore be it

RESOLVED that the House of Delegates of the Kentucky Medical Association strongly urges that the Food and Drug Administration refrains from actions to prohibit the manufacture and sale of useful and reasonably safe combination products, and be it further

RESOLVED that the issuance of drug warnings and information on drugs shall be the appropriate duty of FDA but that these shall likewise be considerate of the actual clinical practice of medicine as well as research and academic factors, and be it further

RESOLVED that copies of this resolution be disseminated to the appropriate federal agencies and to the American and other state medical associations as well as the press.

The above amendment was seconded and carried.

The original motion as amended was also adopted.

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 5 as a whole as amended.

(Seconded; carried)

Mr. Speaker, I wish to express my appreciation to the very fine committee members who served with me and to Mrs. Doris Crume who typed our report.

REFERENCE COMMITTEE NO. 5

Paul J. Parks, M.D., Bowling Green, Chairman
Glenn W. Bryant, M.D., Louisville
John D. Fielding, Jr., M.D., Warsaw
Lowell Martin, M.D., Martin
Richard McElvein, M.D., Lexington

REFERENCE COMMITTEE NO. 6

John M. Baird, M.D., Danville, Chairman

Reference Committee No. 6 considered the following reports:

11. Report of the Judicial Council
12. Report of the Rural Kentucky Medical Scholarship Fund, Board of Trustees
27. Report of the Committee to Study the Constitution and Bylaws
28. Report of the Interim Meeting Program Committee
29. Report of the McDowell House Board of Managers
30. Report of the Memorials Commission
45. Report of the Committee on Plans and Development

Resolution B—Membership of Osteopathic Physicians (Fayette County)

Report of the Judicial Council

The Judicial Council met four times during the 1968-69 Associational year and considered 22 new matters in addition to those carried over from the previous year.

Items of general interest to the profession include the following:

1. The Council, as requested by the 1968 House of Delegates, reconsidered its ruling on the ethics of procedures by which Blue Shield pays for the services of nurse anesthetists, and issued the following statement:

> "The Judicial Council has reviewed its ruling on the ethical considerations surrounding the methods by which the fees of nurse anesthetists are being paid by Blue Shield and is of the opinion that:
>
> (1) a member of an anesthesiology group may ethically submit claims for anesthetics administered by nurse anesthetists employed and supervised by his group and (2) that if the operating surgeon certifies the name of the nurse anesthetist and the type and duration of the anesthetic administered by her, it would not be unethical for a single physician (designated by the medical staff for this purpose) to act as the clearly identified collecting agent for all of the surgeons and submit claims to Blue Shield for all anesthetics administered by nurses who are not employed in an Anesthesiology Department or by an anesthesiology group, and pay over the remittances to the respective nurses (if self-employed) or (if salaried) to their employers."

It later approved an outline of procedure submitted by Blue Shield in which it was provided that the operating surgeon would sign the claim form certifying the name of the lay anesthetist and the type of anesthetic administered to his patient, but payment would be made to a physician designated by the medical staff to act as collecting agent for all operating surgeons, who would distribute the payments to the proper recipients.

2. Hospital-based physicians were informed of the Council's continued concern about their financial arrangements in general and their billing practices in particular, and received representatives of two specialty groups who reported on the present degree of compliance with the Council's 1966 ruling on this subject.

Although the Council remains of the opinion that it is improper for a physician to allow a hospital to bill and collect for his services in any manner other than as the clearly identified agent of the physician, it is uncertain as to the extent of its power to enforce its ruling in the light of the recent consent decree entered by the federal court in the government's anti-trust action against the College of American Pathologists, one paragraph of which enjoined the College and all of its members "and other persons in active concert or participation with any of them" from:

"Requiring or coercing or attempting to require or coerce any person to adopt, adhere to or enforce any criteria established by defendant with respect to (i) the compensation to be paid by any hospital to any laboratory or any laboratory director, or (ii) the purchase or rental by a laboratory or laboratory director from a hospital of space, services, supplies or equipment."

The Council intends, during the coming year, to give this decision continued study and to determine, if possible, its effect upon the power of medical societies to prevent physicians from being reduced to the level of tradesmen whose services can be bought and sold in the market place.

3. A state agency was informed that in the opinion of the Council, a physician cannot be expected to refuse to see a patient who comes to his office with frequent complaints, simply because he carries a Medical Assistance card.

4. Payment by Blue Shield for the services of podiatrists was deemed to be ethical, but no opinion as to the legality of such payments was expressed.

5. The Commission for Handicapped Children was advised that a physician was ethically bound to make his treatment records on a child available to the Commission for professional purposes, even though the physician had not been paid for his services by the parents of the child.

6. A patient was informed that it is ethical for a physician to request that his patient sign an assignment of insurance benefits to the physician, but that he cannot require that this be done before he will fill out the insurance claim forms.

7. A Regional Health Center was advised that it would not be proper for it to employ a psychiatrist on a salary and then submit vouchers to the state on patients seen by him in such numbers that the Center would collect more for the psychiatrist's services than it paid him, since this would amount to exploitation.

8. At the request of the KMA Hospital Committee, the following ethical guidelines for the staffing of emergency rooms were issued:

"To be ethically acceptable, any contract between physician and hospital to staff an emergency department must follow certain basic principles. These principles are clearly stated in the Judicial Council Opinions and Reports of the AMA 1966, Section 6, page 32, paragraph 4 which states:

'A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual by whatever name called or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned.'

"From the legal aspect, a hospital, by law, cannot practice medicine because it cannot meet the qualifications required by the state for that purpose.

"As long as these fundamental ethical and legal principles are not violated, it really makes little difference what type of emergency department contract is entered into between physician and hospital."

"According to the above the following guidelines can be established:

"1. A hospital cannot ethically collect and keep fees for the services of a physician.

"2. It is strongly urged that the physician identify himself to the patient by direct billing to that patient for his services. The hospital charge should be billed separately.

"3. A minimal contractual guarantee by a hospital to a physician for emergency department coverage is discouraged on the basis that if the hospital guarantees the payment fo a certain amount, it more than likely will have some bargaining power regarding the receipt of income *in excess* of that amount.

"4. Hospitals should not charge for physicians' services to cover all or any part of the cost of operation of emergency departments even though all monies received over this cost are divided by the physicians participating.

"5. From time to time, there have been indications that lead one to suspect that hospitals would cherish the role of becoming community health centers, employing fulltime physicians much as they do nurses, aids, orderlies, etc. If medicine is to remain free and independent, then it must of necessity choose the ethical course that will keep the practice of medicine where it rightfully belongs - in the hands of the physicians. One plan could be the formation of a professional service corporation as suggested in the Opinions and Reports of JC AMA where the hospital staff forms a corporation to employ physicians to staff the emergency department. This would indeed fulfill all the ethical requirements.

"6. The Blue Shield's interest is primarily economic. However, a code should be set up to pay for physicians services. The hospital should not be paid for physicians services *under* any circumstances."

9. The medical staff of a hospital was advised that in the opinion of the Council, it is good medical practice and widely accepted for properly trained and supervised nurses to start blood transfusions.

No complaints reached the hearing stage and no disciplinary action was taken against any member during the year, all grievances being resolved by mediation and persuasion.

N. Lewis Bosworth, M.D., Chairman

Recommendations, Reference Committee No. 5

The committee studied in some detail the Report of the Judicial Council, especially Items 3, 4 and 8, on which there were comments from the floor during the discussion. The committee feels that Item 3 should be clarified somewhat in that a physician is not obligated to see a patient merely because he presents a Medical Assistance card, but once he does accept this person as a patient for this particular illness, he is obligated to follow through on his treatment for that particular episode of illness. The committee feels strongly, however, that a physician cannot be expected to police this program, but that he does have the prerogative of notifying the appropriate governmental agency of any apparent over-utilization on the part of the patient.

Item 8 was discussed at length, and the committee realizes that a critical situation exists in the provision of physician coverage in the emergency room department of hospitals, and it is felt that the Judicial Council should continue to seek a workable solution to this problem with particular care that the physician is not exploited by the hospital.

The committee recommends the adoption of the Report of the Judicial Council with the comments noted above.

Mr. Speaker, I move the adoption of this section of the report.

(Motion seconded and carried)

Report of the Rural Kentucky Medical Scholarship Fund

At the 23rd annual meeting of the Rural Kentucky Medical Scholarship Fund held on May 22, 1969, a

total of 35 new and renewal loans were approved amounting to $74,500. The Scholarship Board, in approving these loans, now has a record of having helped a total of 314 students.

The Fund, which was established as a means of providing a better distribution of physicians in rural Kentucky, now has a total of 147 physicians in practice in 80 counties with 12 serving in "critical" counties. There are 26 recipients in the armed services.

There are now outstanding 349 notes to 146 borrowers for a total in excess of $468,000, most of whom are either in medical school, interning or in the armed services. The Fund, since its beginning, using the revolving monies available, has loaned over $944,000.

All loans and contracts are processed at the KMA Headquarters Office. Progress reports are secured on students in medical school, and contact is maintained with interns, recipients in the armed services, those in specialty training and past recipients in practice. The Louisville Trust Company serves as the Fiscal Agent for the Fund. A quarterly financial report is submitted to the Board of Trustees of the Fund.

Loans are available to residents of Kentucky who have been admitted to an accredited medical school, and who will agree to practice in rural Kentucky for one year for each loan received. Currently, the Fund will lend $2,500 to applicants who will agree to practice in counties listed as "critically in need of physicians", or in the Kentucky Public Health Service in an approved area. One year's loan is waived for each year of practice.

Regular loans of up to $1,500 per year at an interest rate of 2% to maturity permit practice in over 100 rural counties in the state. Should a student later decide to practice in a "critical" county, one year's loan will be forgiven for each year of practice. One half a year's loan for each year of practice in a "semi-critical" area will be forgiven.

The 10 critical counties selected for 1969-70, on the basis of information supplied in April by the Kentucky Medical Association and the State Board of Health, are: Jackson, Knott, Crittenden, Metcalfe, Lee, Powell, Wolfe, Meade, McCreary and Rockcastle. Semi-critical areas selected are: Carter-Lewis, Lincoln, Magoffin-Breathitt, Martin, Butler-Edmonson, Clay-Owsley, Clinton-Cumberland, Estill, Owen-Gallatin and Bracken-Robertson.

Twenty-one of the 1969-70 loan recipients have agreed to practice in counties as "critically in need of physicians", and one in the Kentucky Public Health Service.

The Fund also has provided for Establish Practice Loans as an assistance to physicians who will agree to establish practice in a "critical" or "semi-critical" county. The Board will loan $2,000 repayable at the rate of $1,000 per year. The Fund will forgive $1,000 of this amount for each year of practice in a "critical" county, and one-half of this amount for each year of practice in a "semi-critical" area.

The Trustees have elected Billie J. Caudill, M.D. of Morehead, and Donald Chatham, M.D. of Shelbyville as new Board members. Both are previous scholarship recipients of the Fund.

The Board of Trustees is especially appreciative of the continued interest and support of Governor Louie B. Nunn, Health Commissioner Russell E. Teague, M.D. and the Kentucky General Assembly.

C. C. Howard, M.D., Chairman

Recommendations, Reference Committee No. 6

The report of the Rural Kentucky Medical Scholarship Fund, Board of Trustees was considered, and it was noted that the Trustees had elected Billie J. Caudill, M.D. and Donald Chatham, M.D. as new board members. Both were previous scholarship recipients.

The committee recommends that the report of the Rural Kentucky Medical Scholarship Fund be accepted and commends the Fund for a job well done.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Committee to Study the Constitution and Bylaws

This year the committee met on June 19 for its annual session of studying the KMA Constitution and Bylaws and to implement matters that have been referred to it for proposed changes in updating them. We were pleased to have our legal counsel, Mr. E. Gaines Davis, and representatives of the Fayette County Medical Society in attendance.

In reviewing the Bylaws, we note that a comprehensive study of the Constitution and Bylaws would be in order to modernize them and to more closely align them with those of the American Medical Association. In the area of membership categories, for example, we feel some changes are indicated. The committee members also generally felt that eligibility for active membership might be broadened to include "all physicians who hold an unrestricted license to practice medicine and surgery in this state". This terminology would permit osteopaths as active members of KMA when so accepted by county medical societies. While this idea was favorably discussed by our committee, no particular recommendation is being made at this time.

The Board of Trustees referred to us for a recommendation the matter of county societies' bylaws being updated and being in agreement with those of KMA. As it is obvious that much study needs to be done, we recommend that next year's Constitution and Bylaws Committee begin its work early in the Associational year so that a complete study can be undertaken with appropriate changes brought to the 1970 session of the House of Delegates. Following action by the House at that time, the county societies could then utilize the KMA Constitution and Bylaws, as modernized by the House of Delegates in September 1970, as a basis for updating all county society bylaws.

Since we have no constitutional changes this year, our format for presentation is (1) present our recommendations and reasons for submitting the proposed changes, (2) quote the wording of the present section of the Bylaw, and (3) present the proposed amendment to the Bylaw.

Amendments To The Bylaws

RECOMMENDATION

This committee is of the opinion that Chapter I, Section 2(a) of the Bylaws is determinative of the specific question presented by Fayette County as to whether an osteopath could be an active member of that society and an associate member of this Association. That section requires active members of county societies to be doctors of medicine.

It being clear, without question (as to the broader problem) that a physician who is an associate member of a component society could not be an active member of this Association, we can perceive no valid reason why the converse should not apply. However, we recommend that a paragraph as indicated be added to Chapter I, Section 2(a) of the Bylaws.

CHAPTER I, Membership

Present Section 2(a): Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

Proposed Section 2(a): Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical and professional standing, who is licensed to practice medicine in Kentucky. *Nothing contained herein shall prevent a county society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.*

RECOMMENDATION

Last year the Bylaws were changed authorizing only one KMA Vice President instead of three. We overlooked a phrase referring to the Vice Presidents in Chapter II. Section 2 of the Bylaws at that time which is being corrected by the following proposed amendment.

CHAPTER II, Annual and Special Meetings of the Association

Present Section 2: The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Proposed Section 2: The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-elect or *such officers as the Board of Trustees may direct.* The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

RECOMMENDATION

The Board of Trustees suggested that since the Vice President would become President of the Association in the event of the vacancy of the office of President that he should serve on the Executive Committee. To implement this change authorizing eight instead of seven Executive Committee members, the following amendment is proposed.

CHAPTER VI, Board of Trustees

Present Section 1: The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice President, the immediate Past President, the Speaker and Vice Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Proposed Section 1: The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice President, the immediate Past President, the Speaker and Vice Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, *the Vice President,* the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, *5,* shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

RECOMMENDATION

Since the Bylaws have not delineated the categories of membership from which county society delegate strength is authorized, it seems indicated that this matter should be inserted into the Bylaws. It has long been policy to count voting members of a county society when authorizing delegate representation and that is the basis of our proposed amendment.

CHAPTER XII, County Societies

Present Section 12: At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of active members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Proposed Section 12: At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one

delegate for each 25 *voting* members in good standing, plus one delegate for one or more *voting* members in excess of multiples of 25. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of *voting* members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

RECOMMENDATION

The Executive Committee recommended that the title of Executive Secretary of KMA be changed to that of Executive Director in keeping with a trend of both allied health organizations and other state medical associations.

The Constitution and Bylaws Committee recommends that Chapter V, Sections 7 and 8, and Chapter VI, Section 9 be amended to insert the words "Executive Director" in lieu of the words "Executive Secretary" wherever they appear.

Student AMA Members

Our final recommendation does not necessitate a Bylaw change. During the Associational year, the Board of Trustees authorized a representative from the University of Kentucky and the University of Louisville SAMA Chapters to present a report to the House of Delegates and further requested they be given a non-voting seat in the House of Delegates.

In view of the facts that under the Constitution (Article VI, Section 2) all delegates to the House of Delegates must be members of component societies and that Chapter III, Section 17 of the Bylaws gives the House the authority to appoint special committees of non-delegate members and give them the privilege of the floor, *we recommend* that the student members of this Association who are enrolled at the University of Kentucky and the University of Louisville be designated as special committees of the House, and that each committee be authorized annually to elect one representative to give an oral report to the House and to participate in the debate on any matter pending before the House.

Robert L. McClendon, M.D., Chairman

Resolution B

Fayette County Medical Society

WHEREAS, the American Medical Association at its December 1968 meeting granted osteopathic physicians the right to become active members of the American Medical Association; and

WHEREAS, this was reaffirmed at the July 1969 meeting of the American Medical Association leaving the decision to the individual state associations but suggesting that the applicant be approved on a local basis judged by the applicant's local medical colleagues; and

WHEREAS, Chapter I, Section 2(c) of the Kentucky Medical Association's By-Laws now categorizes osteopathic physicians as associate members of the Kentucky Medical Association; and

WHEREAS, for the sake of uniformity of county medical societies, state medical societies, and national medical societies; therefore be it

RESOLVED, that all physicians who hold an unrestricted license to practice medicine and surgery in this state and who possess other qualifications for active membership be eligible for active membership in the Kentucky Medicial Association; and be it further

RESOLVED, that Chapter I, Section 2(a) of the Kentucky Medical Association's By-Laws be amended to read: "Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a *physician who holds an unrestricted license to practice medicine or surgery in this state* and who is of good moral, ethical, and professional standing;" and be it further

RESOLVED, that, in order to comply with the suggestions made by the American Medical Association that the qualification of an osteopathic applicant be judged on the local level, the following criteria should be met:

a) The applicant be a provisional active member for a minimum of one year and a maximum of five years. Depending upon the decision of the county medical society at the end of a provisional active membership of five years, the county medical society should decide whether the applicant is acceptable or not acceptable as an active member of the county medical society and the Kentucky Medical Association. A yearly review of the applicant for a change in membership may be made and/or recommended.

b) Any physician may be refused membership if he fails to meet the other basic requirements that are expected of doctors of medicine.

Recommendations, Reference Committee No. 6

The report of the Committee to Study the Constitution and Bylaws and Resolution B—Membership of Osteopathic Physicians introduced by Fayette County, were considered together. The committee approved the report of the Committee to Study the Constitution and Bylaws with the exception that the proposed amendment to Chapter I, Section 2(a) of the bylaws, should read as follows:

"Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society for requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification."

Therefore, with this amendment to the report of the Committee to Study the Constitution and Bylaws, we feel that Resolution B should be disapproved.

Mr. Speaker, I move the adoption and implementation of this section of the report.

(Seconded)

The Chairman of the Board, Lee Hess, M.D., was recognized to present a motion from the Board on this report.

Doctor Hess stated that the Board, at its September 24, 1969, meeting voted to recommend to the House of Delegates that assuming the amendment offered by the reference committee concerning "Active Members" would be adopted, that Chapter I, Section 2(c)(3) should be deleted, and he so moved.

Following further discussion, during which a motion was made to amend Chapter I Section 2(c) by deleting the words "be ineligible for active membership and", Doctor Hess withdrew his motion. The motion was seconded and carried.

Continuing his report from the Board, Doctor Hess stated that the Board members are of the opinion that Chapter XII, Section 12 should contain assurances that multi-county societies will not lose any of their delegate representation. He then moved that Chapter XII, Section 12 be amended as follows:

"At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25. Provided, however, that each component society shall be entitled to at least one delegate regardless of number of voting members it may have *and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had.* The secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year."

This motion was seconded and carried.

The original motion as amended was then adopted.

Report of the Interim Meeting Program Committee

The Interim Meeting Program Committee met November 13, 1968, at the Continental Inn in Lexington to plan the 1969 session to be held in that location. The facilities of the Continental Inn were inspected, and a review of the 1968 meeting was made prior to considering plans for 1969.

It was agreed to design the format of the program similar to that of the previous year and plans for the promotion of attendance were agreed upon with the Woman's Auxiliary lending appropriate support. Details were finalized for the three sessions scheduled which were the opening dinner session to feature Governor Louie B. Nunn, the following morning's general session, and the closing luncheon meeting. Coordination of the Orientation Program and other related meetings held in conjunction with the Interim Meeting was authorized.

"The Challenge We Face in 1969" was the theme selected with the understanding that the subjects to be highlighted would be Comprehensive Health Planning and Health Manpower. Speakers were then chosen for individual and panel presentations.

We are pleased that a record 336 physicians, Auxiliary members, and guests registered for the meeting, and your committee wishes to express appreciation to the Fayette County Medical Society and the Woman's Auxiliary for their cooperative efforts in helping make this program a success.

Henry B. Asman, M.D., Chairman

Recommendations, Reference Committee No. 6

The committee studied the Interim Meeting Program Committee report and recommends its adoption as submitted.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the McDowell House Board of Managers

In the course of four meetings of the Board of Managers held at the McDowell House during the year, various repairs and improvements have been authorized. A deteriorated furnace has been replaced with a combination furnace and air-conditioning unit which employs the same ducts. This will aid in preservation of the House and its antique furnishings as well as the comfort of visitors. A large retaining wall on the back side of the property has collapsed and is being replaced. The interior of the House has been repainted under the expert guidance of Mr. James Cogar. Constant improvements in restoration add to the authenticity of the Shrine. Descendants of Adeline McDowell Deaderick (one of Doctor McDowell's daughters) have presented her portrait to the House.

During the year an estimated 5,000 visitors have been in the House, a continuing increase. Included was Doctor Richard Hanley, chief surgeon of the Middlesex Hospital in London, England. Doctor Hanley was most impressed with the McDowell story and the restoration of the House, as is everyone.

The availability of the House for council and committee meetings of the Association should be kept in mind. The interest and constant help of the state and various county auxiliaries are important factors in the success of the House. These organizations are urged to use the House for their meetings. Slides of the House may be obtained and the committee members are available to aid in any county or state meetings.

The committee recommends that the Board of Trustees authorize the formation of a McDowell House Foundation, to which donations and bequests may be given as an endowment fund for the upkeep of the House.

I want to take this opportunity to thank the Board of Managers for their continuing interest, hard work and time in behalf of McDowell House. They are: Robert C. Bateman, M.D., Danville; B. B. Baughman, M.D., Frankfort; Mr. Sterling Coke, Lexington; Mr. James Cogar, Harrodsburg; Mr. George Grider, Danville; Blaine Lewis, M.D., Louisville; Richard H. Segnitz, M.D., Lexington; Mr. Earl P. Slone, Lexington; Mr. Enos Swain, Danville; and Francis Massie, M.D., Lexington.

Laman A. Gray, M.D., Chairman

BOARD ACTION: Approved with the exception that the Board recommends deferring action on the formation of the Foundation until such time as legal counsel has had an opportunity to study a method by which this should be done. It is further understood that when such action does take place it will be at the expense of the McDowell House funds.

Recommendations, Reference Committee No. 6

The committee studied the report of the McDowell House Board of Managers, and it was noted that the Board of Managers proposed the formation of the McDowell House Foundation, to which donations and bequests might be given as an endowment fund for the upkeep of the House.

The committee recommends the adoption of this report with the reservation expressed by the Board of Trustees which was that the formation of the foundation be deferred until legal counsel could determine whether the same result could be accomplished by the creation of a tax-exempt fund within KMA (such as the Postgraduate Medical Education Fund), and with the further understanding that when such action does take place, it will be at the expense of the McDowell House Board of Managers.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and carried)

Report of the Memorials Commission

The Memorials Commission met once during the past year, on April 17, 1969, at the KMA Headquarters.

The Commission takes pleasure in acknowledging receipt of several books from members of our Association. William W. Hall, M.D. of Owensboro, sent us a copy of Henry Miller's *Principles and Practice of Obstetrics,* Philadelphia, 1858, and James M. Stevenson of Brooksville presented our Association with a copy of Lewis Collins' *History of Kentucky*. These books are available for use in the bookcase in the President's Office at Headquarters.

Your chairman, at the kind invitation of Mrs. William McBeath, President of the KMA Auxiliary, met with Mrs. McBeath and Mrs. C. D. VanArsdall, Jr. in Harrodsburg to examine the exhibits of instruments, books, and other equipment used by early Kentucky physicians. These materials had been collected by the KMA Auxiliary over a number of years and the Doctor's Shop at the state park in Harrodsburg had been originally operated by members of the Auxiliary of KMA. Since it has become a state park the contents of the shop have been assumed to be state property. The Auxiliary is to examine the possibilities of the KMA Auxiliary reacquiring or borrowing some of its former properties so they may be placed in the museum at Headquarters.

The Commission is still in search of copies of *Transactions of the KMA* and is now in the process of determining the feasibility and cost of obtaining microfilm copies of extant *Transactions* from various libraries. In this manner it is hoped we may assemble at least one complete file of these important records of our Association.

The Commission will have an exhibit at the KMA meeting memorializing Lewis S. McMurtry, M.D. and also presenting some information on "Home Medical Guides" which were immensely important throughout early years of settlement of this country.

At the suggestion of J. Duffy Hancock, M.D., an effort is being made to change the name of Janet Avenue to the name of some famous Kentucky physician. The Commission suggested Dr. William L. *Sutton,* Dr. Irving *Abell,* or Dr. Ephraim *McDowell* as names more appropriate for the street address of the KMA Headquarters.

Eugene H. Conner, M.D., Chairman

Recommendations, Reference Committee No. 6

The committee reviewed the Report of the Memorials Commission and recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded; carried)

Report of the Committee on Plans and Development

The KMA Plans and Development Committee came into existence this year as a result of a motion approved by the Board of Trustees on September 26, 1968, which stated that:

"The Board of Trustees create a Committee on Plans and Development as a permanent committee of the Association, and direct the Chairman of the Board, after due consideration and consultation with the members of the Board, to determine the most desirable size and makeup of this committee and the advisability of including representatives of academic medicine, industrial and institutional medicine, the younger group of physicians in private practice and, perhaps, representatives of SAMA, as well as those members who are more experienced in the organizational and administrative operations of the Association".

At a later date, the Board decided that this committee would be composed of 12 members who would have rotating terms of three years, plus a representative from each of the medical schools, and SAMA for a total of 16.

Our first meeting was held on March 6 at which time our complete membership had not been appointed, and we were charged with the responsibility of expanding our committee from eight to 16 members. This session was strictly for organizational purposes, and we were pleased to have the KMA President Henry B. Asman, M.D., in attendance to present to us the long-range goals and areas of responsibility being assigned to us. The committee members were asked to submit projects and proposals for future consideration.

Our second and final meeting of the year was also of an organizational nature and was held on April 10. It was unanimously agreed that no definitive recommendations could be presented during this first year of operation, but ground work could be laid for a productive future.

Some discussion was held during this session concerning administrative matters such as lightening the load of the president, specialty group cooperation, and executive staff assignments. Organizationally, we discussed methods to increase interest and participation in KMA affairs, health planning, multi-county medical societies, the involvement of young physicians in KMA, and similar subjects.

It is felt that as the committee enters into the next Associational year more background material will be available and progress can be made toward fulfilling our goals.

Since our projects are all encompassing, we sincerely solicit the opinions of all KMA members on any matter relating to present or future activities of our Association.

George A. Sehlinger, M.D., Chairman

Recommendations, Reference Committee No. 6

The committee reviewed the report of the Committee on Plans and Development. There were no recommendations from the committee on this report. The committee approved the report as presented.

Mr. Speaker, I move the adoption of this section of the report.

(Seconded and passed)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 6 as a whole as amended.

(Seconded; carried)

Mr. Speaker, I wish to thank the members of the committee for their attendance and help in the preparation of this report, and especially, I wish to thank our legal counsel, Mr. E. Gaines Davis, for his able assistance at this time.

REFERENCE COMMITTEE NO. 6

John M. Baird, M.D., Danville, Chairman
John F. Berry, M.D., Lexington
Elbert G. Christian, M.D., Louisville
William D. Epling, M.D., Berea
John Rypstra, M.D., London

Unfinished Business

Doctor Greathouse recognized Lee C. Hess, M.D., Chairman of the Board of Trustees for the final report of the Board, which read as follows:

The KMA Bylaws provide that the Judicial Council be composed of five members, four of these members to be elected by the House of Delegates with terms staggered so that one member will be elected each year. The KMA Secretary, who is elected by the House, automatically serves as a member of the Council.

According to the Bylaws, Chapter VII, Section I, "to be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA, or (2) Have served five years as a member of the House of Delegates."

The Bylaws provide that the Board of Trustees shall nominate at least one candidate for each vacancy and that additional nominations may be made from the floor.

The term of N. Lewis Bosworth, M.D., Lexington, expires with this meeting. The Board of Trustees has unanimously voted to nominate Doctor Bosworth to succeed himself for a four year term.

Doctor Hess moved the adoption of this report. The motion was seconded and carried.

Election of Officers

The Speaker called for the Report of the Nominating Committee from its Chairman, Fred C. Rainey, M.D., Elizabethtown. Doctor Rainey read the following list of nominations for the positions noted:

President-elect (Western)	John C. Quertermous, M.D., Murray
Vice President (Eastern)	David A. Hull, M.D., Lexington
Secretary	S. Randolph Scheen, M.D., Louisville
Treasurer	Keith P. Smith, M.D., Corbin
AMA Delegate	George F. Brockman, M.D., Greenville
AMA Alternate Delegate	Daryl P. Harvey, M.D., Glasgow
AMA Delegate	Charles C. Rutledge, M.D., Hazard
AMA Alternate Delegate	David B. Stevens, M.D., Lexington

Following the presentation of each nomination, the Speaker called for nominations from the floor. Since no additional nominations were received, it was moved and seconded that the nominees be elected. Motion carried.

Doctor Quertermous, the President-Elect, was escorted to the podium and received a standing ovation.

The following nominations for the office of trustee and alternate trustee were also submitted by Doctor Rainey on behalf of the various district nominating committees:

Fifth District	John S. Llewellyn, M.D., Louisville
Alternate	Lloyd G. Yopp, M.D., Louisville
Sixth District	Paul J. Parks, M.D., Bowling Green
Alternate	Carlisle V. Dodson, M.D., Russellville
Eighth District	Lee C. Hess, M.D., Florence
Alternate	Carl J. Bruggemann, M.D., Covington
Eleventh District	Douglas H. Jenkins, M.D., Richmond
Alternate	Hugh Mahaffey, M.D., Richmond
Fifteenth District	E. C. Seeley, M.D., London
Alternate	Harold L. Bushey, M.D., Barbourville

The same procedure followed in the election of the general officers was followed in the election of the trustees and alternate trustees. There were no additional nominations from the floor, and the above-named nominees were elected.

Nominations For Kentucky Physicians Mutual, Inc. Board of Directors

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted and received for information only.

John Dickinson, M.D., Glasgow
John D. Gordinier, M.D., Louisville
William W. Hall, M.D., Owensboro
Coleman Johnston, M.D., Lexington
Richard J. Rust, M.D., Newport
Garnett Sweeney, M.D., Liberty
Wyatt Norvell, M.D., New Castle
Peter P. Bosomworth, M.D., Lexington
Henry B. Asman, M.D., Louisville
Hoyt Gardner, M.D., Louisville
Charles Moran, M.D., Louisville
Richard Grise, M.D., Bowling Green
Lee C. Hess, M.D., Florence
John Quertermous, M.D., Murray
George Brockman, M.D., Greenville

Election of 1970 Nominating Committee

Elected to serve as the Nominating Committee for the 1970 Annual Meeting were the following physicians:

W. E. Becknell, M.D., Manchester
Clyde Brassfield, M.D., Elizabethtown
Thomson R. Bryant, M.D., Lexington
W. Faxon Payne, M.D., Hopkinsville
W. Fielding Rubel, M.D., Louisville

Walter L. Cawood, M.D., Ashland, was installed as President, with the oath of office being administered by the Chairman of the Board of Trustees, Lee C. Hess, M.D. President Cawood then presented the Past President's Plaque to the retiring president, Henry B. Asman, M.D., expressing appreciation on behalf of the members of KMA, for his loyal, dedicated and untiring efforts for this Association.

Doctor Asman invited all members and guests to a reception in his suite honoring the new President immediately following adjournment of the House.

The new President-Elect, John Quertermous, M.D., made brief remarks to the members of the House, thanking them for their confidence in electing him to this position.

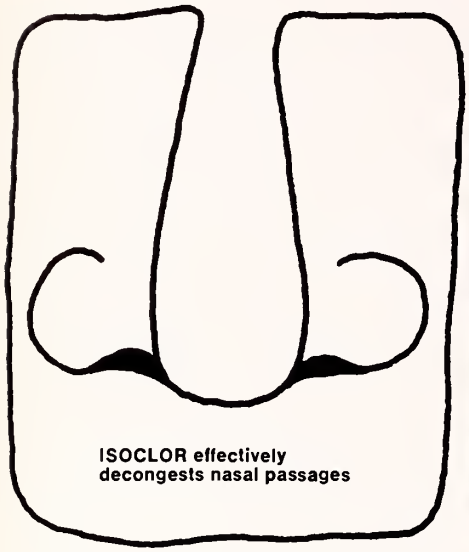
Doctor Scheen announced that the Board of Trustees would hold its reorganization meeting on Thursday, at 12:00, in Parlor A at the Kentucky Hotel and urged the newly elected Board members to attend.

Speaker Greathouse adjourned the second session of the 1969 House of Delegates at 11:10 p.m., thanking the delegates for their time, attention and efforts.

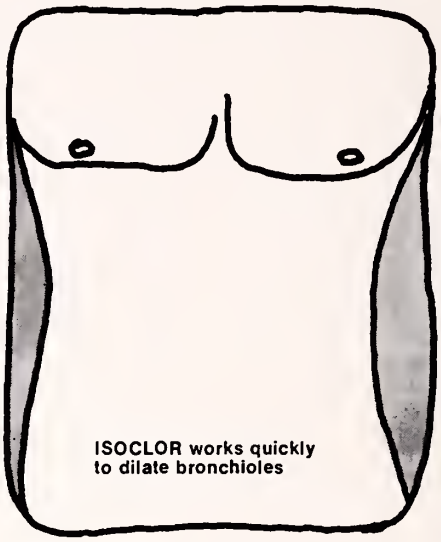
★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
Suite 260
Shelbyville Road Mall Office Center
400 Sherburn Lane
Telephone: (Area Code 502) 895-5501
Mailing Address: P.O. Box 20065, Louisville, Kentucky 40220

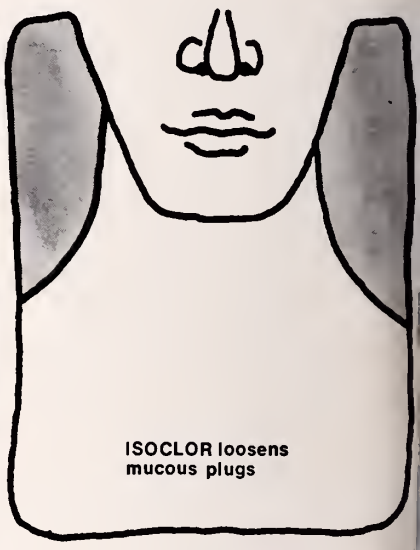
HERE ARE THE COLD FACTS:



ISOCLOR effectively decongests nasal passages



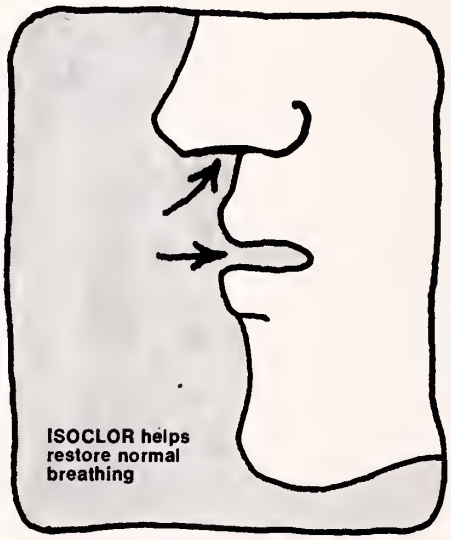
ISOCLOR works quickly to dilate bronchioles



ISOCLOR loosens mucous plugs



ISOCLOR relieves runny eyes



ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza



ISOCLOR helps patients face the cold facts

ISOCLOR®

Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
Chlorpheniramine Maleate.....4 mg.
Pseudoephedrine HCl.....25 mg.

Each ISOCLOR Timesule contains:

Chlorpheniramine Maleate.....10 mg.
Pseudoephedrine HCl.....65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For symptomatic relief of colds, hay fever, allergic conjunctivitis, perennial rhinitis of allergic origin and sinusitis. Opens nasal, sinus and bronchial passages orally.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathc mimetic agents. Severe hypertension or severe cardiac diseas

PRECAUTIONS: Use with caution in patients suffering with hy perthyroidism. Patients susceptible to the soporific effects chlorpheniramine should be warned against driving or operatir machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescriptio

SUPPLIED: Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottle pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

ARNAR-STONE LABORATORIES, INC.
QUALITY—RESEARCH—SERVICE
SUBSIDIARY OF AMERICAN HOSPITAL SUPPLY CORPORATION
Mount Prospect, Illinois 60056

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



The mucosa: specific analgesia usually within 30 minutes

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Interstitial fluids: ready diffusion of antibacterial

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient *b.i.d.* dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes *E. coli* and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

ROCHE

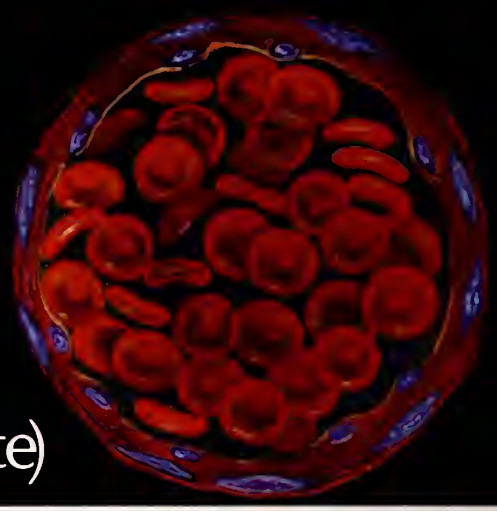
Roche LABORATORIES

Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



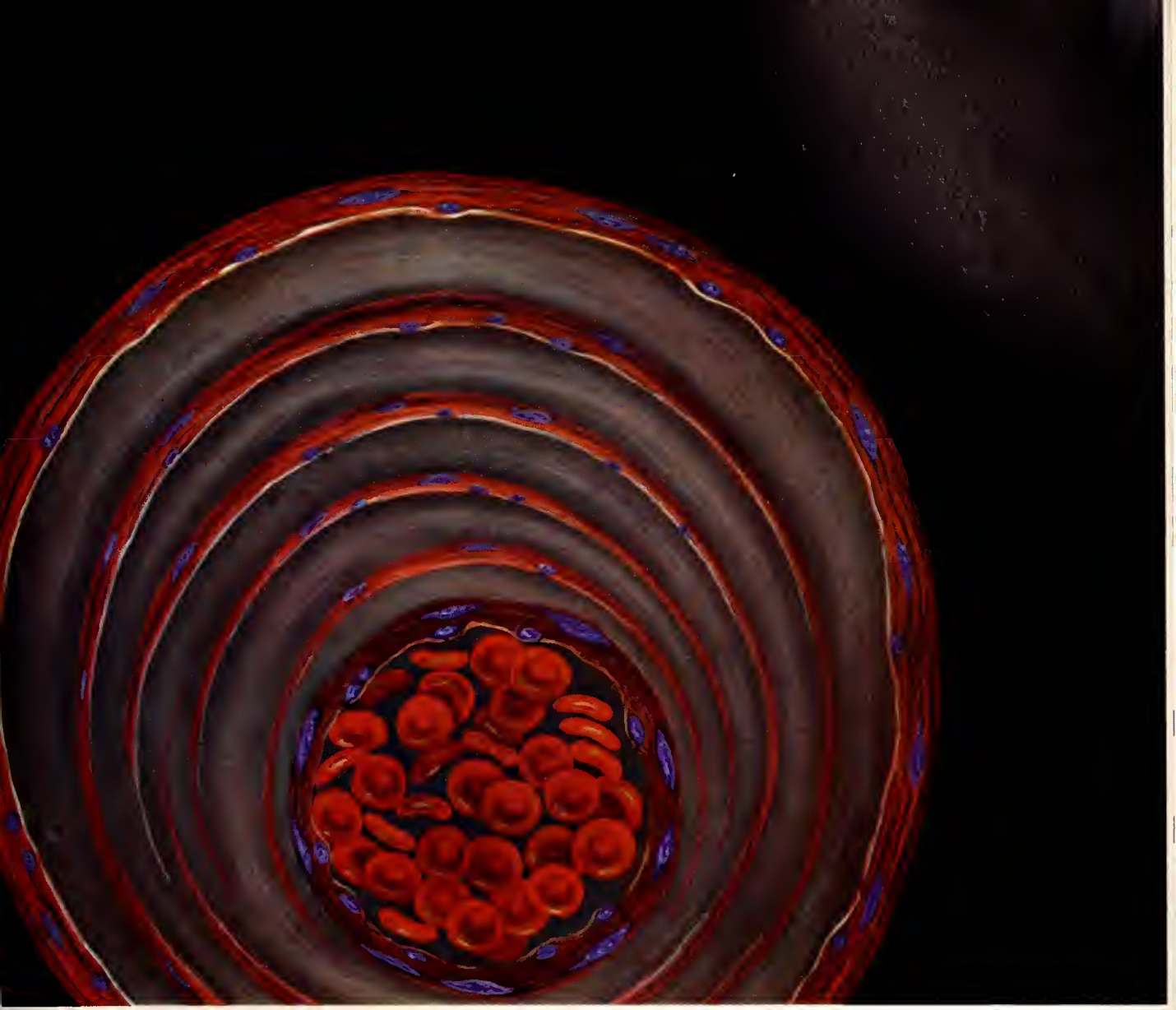
Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided sustained-release Roniacol Timespan (nicc alcohol tartrate) Tablets. Part of the drug b comes available immediately, the remaind continuously over a period of up to 12 hou and dilation of constricted peripheral vess usually maintained. Thus, with a single dos medication, patients can enjoy the benefit increased peripheral blood flow in ischem extremities for up to 12 hours.



mooth peripheral vasodilation from initial osage...extended with mple, well-tolerated, b.i.d. dosage

e prolonged action of Roniacol Timespan cotinyl alcohol tartrate) together with its er benefits offer a therapeutically practical asure in the long-term management of ipheral vascular disease–advantages ecially important for older patients.

ore prescribing, please consult complete duct information, a summary of which ows:

ications: Conditions associated with cient circulation; e.g., peripheral vascular ase, vascular spasm, varicose ulcers, ubital ulcers, chilblains, Meniere's syne and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



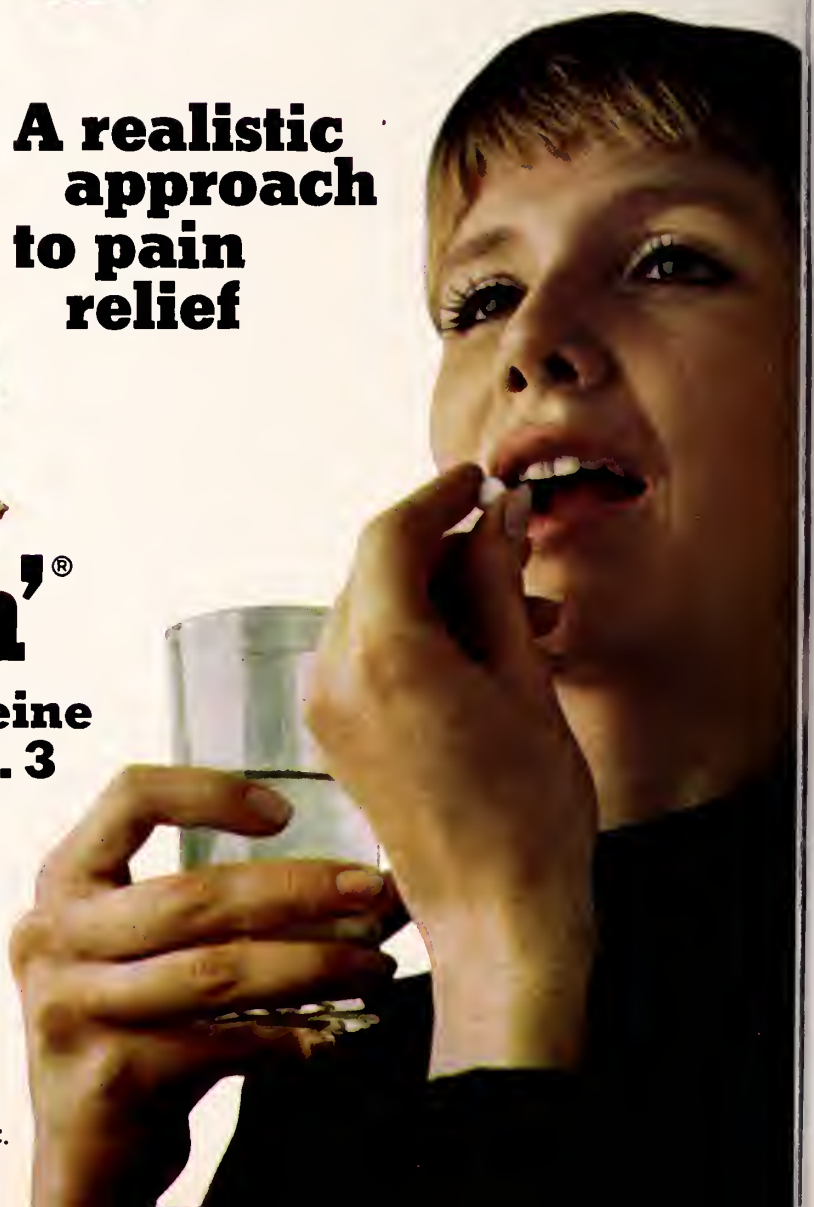


The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

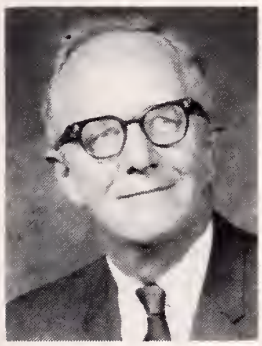
'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

ORGANIZATION SECTION

Dr. Long Announces Candidacy For AMA President-Elect

Robert C. Long, M.D., Louisville, will be a candidate for the office of President-Elect of the American Medical Association, according to officials of the Kentucky Medical Association who met on October 28 to announce this decision. The election will be held at the 1970 AMA Annual Meeting in Chicago on June 21-25.



Doctor Long

During his more than 20 years in the private practice of medicine, Doctor Long has been closely associated with his County Medical Society, the Kentucky Medical Association and the American Medical Association. His long list of activities is indicative of his preparation for organized medicire's most demanding and important position.

Doctor Long is a fourth generation physician. His father, grandfather and great-grandfather practiced medicine in Kentucky over a period of many years. His father was President of the Jefferson County Medical Society in 1929.

Having earned his A.B. and M.D. degrees from the University of Louisville, Doctor Long served his internship at Louisville General Hospital lying-in first year residency at Chicago, and thereafter entered the Armed Forces of the United States where he served with high distinction. As a flight surgeon in the Army Air Force, he was decorated with the Bronze Star during service in China and then discharged as a Major in 1946.

Doctor Long was a member of the KMA Board of Trustees for more than 10 years. During this period, he served as a member of the AMA House of Delegates from 1956 through 1963. In that year he was elected to the Board of Trustees of AMA and has served continuously since that time.

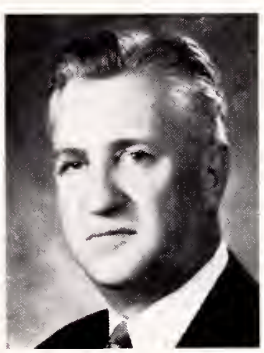
Recently, Doctor Long accepted the chairmanship of AMA's Committee on Health Care for the Poor. Also, during 1969 he began serving as President of the AMA Education and Research Foundation. Along with his many years of service to his county, state and national medical associations, he has found time to serve his own specialty group. A Diplomate of the American Board of Obstetrics and Gynecology since 1950, Doctor Long has been chairman of the Committee on Medical Service Plans of District Five of the American College of Obstetrics and Gynecology.

At its October 28 meeting, the leadership of KMA enthusiastically reaffirmed its endorsement of Doctor Long's candidacy and pledged its full support toward his election next June as President-Elect of the American Medical Association.

J. Ed McConnell To Speak At 1970 Interim Meeting

"Kentucky Medicine in the Seventies" is the theme for the 1970 Interim Meeting of the Kentucky Medical Association, reports Walter L. Cawood, M.D., KMA president and chairman of the Interim Meeting Program Committee. The Meeting will be held April 8 and 9 at Kentucky Dam Village State Park, Gilbertsville.

J. Ed McConnell, president of Kentucky Physicians Mutual, Inc. and Blue Cross Hospital Plan, Inc., will be the featured speaker at the April 9 luncheon. One of Kentucky's most sought-after speakers, both from within and outside the state, was employed by Blue Cross in 1942 and has served that organization as assistant director, vice president and executive vice president.



Mr. McConnell

Delivering the keynote address at the evening session on April 8 will be a top official of the American Medical Association. The topic will be "Health Care in the Seventies."

Other topics for the two-day program are "Peer Review" with guest speakers giving the national picture, the consumer's viewpoint, and Kentucky's guidelines on this subject, and "Physician's Assistants" with a panel presentation featuring recognized authorities from both the state and national levels who will speak on the role of the physician assistant. The names of the speakers will appear in the January issue of *The Journal.*

Planned in connection with the Interim Meeting are an Orientation Program for new members of KMA and a meeting of the Woman's Auxiliary to KMA. Doctor Cawood urges all physicians to make their reservations early and to read the December *Communicator* for further reservation details.

KMA Surpasses 2400 Mark With Addition of 22 New Members

For the first time in its history, the Kentucky Medical Association reports 2400 active members. Including inactive, associate, emeritus, service, retired and transfer members, the total membership is 2768, according to records of the membership department as of November 25.

Twenty-two physicians have recently joined KMA as active members. Four new members from Louisville are Joanne D. Corum, M.D., Gordon L. Gutmann, M.D., David S. Nightingale, M.D., and William M. Schreiber, M.D.

New members from Lexington include Robert P. Belin, M.D., William S. Bost, Jr., M.D., Glenn E. Hair, M.D., Daniel C. MacDougall, M.D., John E. Plumlee, M.D. and Matthew C. Shaw, M.D.

Paducah physicians joining KMA recently include Charles E. Hogancamp, M.D., Glenn E. Hogancamp, M.D., J. Jeff Johnson, M.D., and Elmer W. Ylitalo, M.D.

Other new members are Jim K. Goodrum, M.D., Bowling Green; Allen J. Hamon, M.D., Carlisle; William P. McElwain, M.D., Frankfort; Frederick E. DePriest, M.D. and Lincoln M. de Sousa, M.D., both of Harlan; Joseph D. Alter, M.D. and Marshall Tad Morgan, M.D., both of Hazard, and Tom Evans, Jr., M.D., Henderson.

Dr. C. Kenneth Peters Elected As KEMPAC Board Chairman

C. Kenneth Peters, M.D., Louisville, was elected chairman of the KEMPAC Board at its annual meeting November 13. Doctor Peters succeeds John C. Quertermous, M.D., Murray, KMA President-Elect.

Elected as KEMPAC secretary-treasurer was R. Burke Casper, M.D., Louisville. New Board members are John S. Oldham, M.D., Owensboro (2nd Congressional District representative); Carl J. Brueggemann, M.D., Covington (4th); John P. Hill, Jr., M.D., Somerset (5th); Carl H. Scott, M.D., Lexington (6th), and Max D. Jones, M.D., Pikeville (7th).

Membership in KEMPAC is at an all-time high, according to records in the KEMPAC office.

Book On Chiropractic Available To Kentucky Physicians

Copies of the book entitled *At Your Own Risk, the case against chiropractic,* by Ralph Lee Smith, are now available to Kentucky physicians at fifty cents a copy, if purchased from the KMA Headquarters Office, according to David B. Stevens, M.D., chairman of the Committee on Cults.

This independently written, privately published book is being used as a major tool in medicine's attempt to inform the public, and especially the legislators, about chiropractic.

It was suggested by the Committee on Cults that a number of physicians would want to make the book available to their patients by displaying it in their waiting rooms.



Attending the first planning conference for the 1975 revision of the United States Pharmacopeia were (left to right): E.C. Seeley, M.D., London, KMA delegate to the U.S.P. convention; William M. Heller, Ph.D., Executive Director of the U.S.P., Washington, D.C., and Joseph V. Swintosky, Ph.D., dean of the University of Kentucky College of Pharmacy.

Dr. Seeley Represents KMA At U.S.P. Conference Oct. 20

A conference concerning the United States Pharmacopeia was conducted by the College of Pharmacy of the University of Kentucky on October 20. Composed of representatives from both pharmacy and medicine in Kentucky, the conference was the first of its kind ever held in the 150-year history of the United States Pharmacopeia Convention.

E. C. Seeley, M.D., London, represented the Kentucky Medical Association at the conference. Other representatives of medicine were Charles W. Gorodetsky, M.D., U.K. College of Medicine; Donald E. Knapp, Ph.D., D.D.S., U.K. College of Dentistry; Russell E. Teague, M.D., Kentucky Department of Mental Health and Harold O. Klingele, M.D., University of Louisville School of Medicine.

The purpose of the U.S.P. conference was to attempt to find ways of making the U.S.P. have greater usefulness in pharmaceutical and medical practice. Such information will guide in planning the 1975 revision of the U.S.P.

KNA Elects 1st President-Elect At 63rd Annual Convention

The Kentucky Nurses Association chose, for the first time, a president-elect at their 63rd Annual Convention, held October 22-24 at the Kentucky Hotel, Louisville.

Mrs. Effie Kemp, Paducah, former KNA vice president, will serve as the Association's president-elect for the 1969-70 year. Mrs. Ruth Spurrier, elected KNA President for a two-year term in 1968, presided at the convention.

The theme of the three-day meeting was "Unity" and topics discussed included "Cardiac Emergencies," "How to Work with Older People," "Professional Nursing and the Social Interest," and "Freedom to Achieve."

Miss Louise Jimm, Lexington, was elected vice president and Miss Mary Margaret Walters, Louisville, was named KNA secretary.

KMA Committees and Commissions for the 1969-70 Associational Year

ANNUAL MEETING ACTIVITIES

Scientific Program Committee

Allan M. Lansing, M.D., Louisville, Chairman
Walter L. Cawood, M.D., Ashland
John C. Quertermous, M.D., Murray
Peter P. Bosomworth, M.D., Lexington
R. Glenn Greene, M.D., Owensboro
Ralph M. Denham, M.D., Louisville
J. Sankey Williams, M.D., Nicholasville

Scientific Exhibits Committee

T. R. Marshall, M.D., Louisville, Chairman
J. William Hollingsworth, M.D., Lexington
Benjamin B. Jackson, M.D., Louisville
Arnold C. Williams, M.D., Lexington

Awards Committee

Richard F. Grise, M.D., Bowling Green, Chairman
William A. Blodgett, M.D., Louisville
Frank L. Duncan, M.D., Monticello
C. Wayne Franz, M.D., Ashland
Douglas E. Scott, M.D., Lexington

MEDICAL EDUCATION AND HOSPITALS

Committee on Medical Education

Walter I. Hume, Jr., M.D., Louisville, Chairman
Douglas M. Haynes, M.D., Louisville
William S. Jordan, Jr., M.D., Lexington
Frank R. Lemon, M.D., Lexington
Elmer G. Prewitt, M.D., Corbin
Carl H. Scott, M.D., Lexington
William J. Temple, M.D., Covington

Subcommittee on Coronary Care Units

Henry W. Post, M.D., Louisville, Chairman
M. Cary Blaydes, M.D., Lexington
Robert L. Hast, M.D., Owensboro
William B. Russell, M.D., Bowling Green
Gerard A. Weigel, M.D., Somerset

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman
Clyde M. Brassfield, M.D., Elizabethtown
Carl J. Brueggemann, M.D., Covington
John E. Cotthoff, M.D., Hopkinsville
Royce E. Dawson, M.D., Owensboro
Lewis Dickinson, M.D., Glasgow
James L. Ferrell, M.D., Paris
Ellis A. Fuller, Jr., M.D., Louisville
W. Fielding Rubel, M.D., Louisville
Okey H. Sanford, M.D., Ashland
Warren E. Sloan, M.D., Paducah
Oscar W. Thompson, Jr., M.D., Pikeville
Cordell H. Williams, M.D., Hazard

Committee on Educational Television

Thomas L. Heavern, Jr., M.D., Highland Heights, Chairman
R. K. Brown, M.D., Georgetown
Kearney B. Daniel, Jr., M.D., Danville
John B. Floyd, Jr., M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Eli Khouri, Jr., M.D., Paducah
Frank R. Lemon, M.D., Lexington
James B. Tolliver, M.D., Whitesburg
William P. VonderHaar, M.D., Louisville

Technical Advisors

Frank Miller, Program Director, WAVE, Louisville
Victor A. Sholis, WHAS, Louisville
Leonard Press, Director, ETV for Kentucky, Lexington

Disaster Medical Care Committee

William T. Rumage, Jr., M.D., Louisville, Chairman
Howell J. Davis, M.D., Owensboro
George E. Estill, M.D., Maysville
Richard D. Floyd, M.D., Lexington
Donald C. Haugh, M.D., Mayfield
E. Truman Mays, M.D., Louisville
Robert E. Reichert, M.D., Covington
John A. Ritter, M.D., Harlan

Cancer Coordinating Committee

Condict Moore, M.D., Louisville, Chairman
John W. Ambach, Sr., M.D., Louisville
C. Melvin Bernhard, M.D., Louisville
Robert H. English, M.D., Henderson
Edward J. Fadell, M.D., Louisville
Robert H. Greenlaw, M.D., Lexington
William R. Jewell, M.D., Lexington
Frank R. Pitzer, M.D., Hopkinsville
Benjamin F. Roach, M.D., Midway
Ralph M. Scott, M.D., Louisville
G. Robert Tanner, M.D., Ft. Thomas
Robert C. Tate, M.D., Louisville

MEDICAL SERVICES

Advisory Committee to Blue Shield

Kenneth P. Crawford, M.D., Louisville, Chairman—Pediatrics
Walter R. Brewer, M.D., Lexington—Urology
Marvin A. Bowers, Jr., M.D., Louisville—Anesthesiology
Charles O. Bruce, Jr., M.D., Louisville—Ophthalmology
Thomas J. Ferriell, Jr., M.D., Elizabethtown—General Practice
James A. Holbrook, M.D., Prestonsburg—General Practice
W. Donald Janney, M.D., Covington—Radiology
C. Nicholas Kavanaugh, Jr., M.D., Lexington—Internal Medicine
J. Keith Linville, M.D., Central City—Internal Medicine
James T. McClellan, M.D., Lexington—Pathology
Robert L. McClendon, M.D., Louisville—Internal Medicine
Willis P. McKee, M.D., Shelbyville—Surgery
William K. Massie, Jr., M.D., Lexington—Orthopedic Surgery
Okey H. Sanford, M.D., Ashland—General Practice
David C. Shipp, M.D., Louisville—Proctology
Edwin P. Solomon, M.D., Louisville—Obstetrics & Gynecology
Harvey R. St. Clair, M.D., Louisville—Psychiatry
Wellington B. Steward, M.D., Lexington—Pathology
Garnett J. Sweeney, M.D., Liberty—General Practice
John C. Weeter, M.D., Louisville—Plastic Surgery

Advisory Committee to Blue Cross

George W. Pedigo, M.D., Louisville, Chairman
Dwight L. Blackburn, M.D., Berea
Robert M. Blake, M.D., Maysville
Milton Comer, M.D., Louisville
James R. Dade, M.D., Hopkinsville
Robert L. Davis, M.D., Winchester
Marvin B. Dillon, M.D., Paris
Richard F. Grise, M.D., Bowling Green
James B. Holloway, M.D., Lexington
James M. Keightley, M.D., Harrodsburg
Esten S. Kimbel, M.D., Frankfort
Howard B. McWhorter, M.D., Ashland
Theodore T. Myre, M.D., Paducah
Sam A. Overstreet, M.D., Louisville
James R. Schrand, M.D., Florence
John J. Sonne, M.D., Bardstown

Committee on Occupational Health Physical Medicine & Rehabilitation

John E. Eckerle, M.D., Louisville, Chairman
William K. Massie, Jr., M.D., Lexington
Joseph E. Kutz, M.D., Louisville
Thomas M. Marshall, M.D., Louisville
Walter L. O'Nan, M.D., Henderson
John E. Trevey, M.D., Lexington

Maternal Mortality Study Committee

John A. Petry, M.D., Fern Creek, Chairman
John W. Ambach, Sr., M.D., Louisville
Glenn W. Bryant, M.D., Louisville
Joe M. Bush, M.D., Mt. Sterling
James R. Collins, M.D., Lexington
Joseph F. Daugherty, M.D., Florence
Preston V. Dilts, Jr., M.D., Lexington
William C. Durham, M.D., Louisville
Donald E. Edger, M.D., Lexington
Lewis Francis, M.D., Lexington
John D. Handley, M.D., Hodgenville
Edwin H. Hanekamp, M.D., Owensboro
Douglas M. Haynes, M.D., Louisville
Robert L. Houston, Jr., M.D., Eminence
George C. McClain, M.D., Benton
Clarence J. McGruder, M.D., Henderson
R. D. Pitman, M.D., Williamsburg
Jere C. Robertson, M.D., Hopkinsville
John H. Siehl, M.D., Covington
James F. Williamson, M.D., Ashland
Walter M. Wolfe, Jr., M.D., Louisville
John W. Greene, M.D., Lexington
Robert J. Griffin, M.D., Lexington

MISCELLANEOUS ACTIVITIES

Advisory Committee to Selective Service

Glenn U. Dorroh, M.D., Lexington, Chairman
Sam A. Overstreet, M.D., Louisville, Vice Chairman
George P. Archer, M.D., Prestonsburg
Willard M. Buttermore, M.D., Corbin
Sydney G. Dyer, M.D., LaCenter
J. Duffy Hancock, M.D., Louisville
Alvin D. Poweleit, M.D., Covington
Russell E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
Tom F. Whayne, M.D., Lexington
George H. Widener, Jr., M.D., Paducah
Walter M. Wolfe, M.D., Louisville
Marcus G. Randall, D.D.S., Louisville
L. S. Shirrell, D.V.M., Frankfort
Miss Celestia Uftring, R.N., Louisville

Committee to Study the Constitution and Bylaws

Robert L. McClendon, M.D., Louisville, Chairman
Matthew C. Darnell, Jr., M.D., Lexington
Edwin R. Davis, M.D., Hopkinsville
Mitchel B. Denham, M.D., Maysville
Lawrence T. Hiltz, M.D., Covington
Max P. Jones, M.D., Pikeville
R. J. Phillips, M.D., Owensboro
Michael D. Thomas, M.D., Somerset
Charles A. Webb, M.D., Ashland

Interim Meeting Program Committee

Walter L. Cawood, M.D., Ashland, Chairman
John C. Quertermous, M.D., Murray
William W. Hall, M.D., Owensboro
Thornton E. Bryan, Jr., M.D., Cadiz
Mrs. Hoyt Gardner, President, Woman's Auxiliary, Louisville
Gabe A. Payne, Jr., M.D., Hopkinsville

Committee on Plans and Development

Thornton E. Bryan, M.D., Cadiz, Chairman (1970)
Henry B. Asman, M.D., Louisville (1972)
Robert M. Blake, M.D., Maysville (1971)
Carl J. Brueggemann, M.D., Covington (1970)
Douglas M. Haynes, M.D., Louisville
Frank R. Lemon, M.D., Lexington
Robert N. McLeod, Jr., Somerset (1971)
Dan A. Martin, M.D., Madisonville (1970)
Paul J. Parks, M.D., Bowling Green (1972)
Robert E. Pennington, M.D., London (1972)
William J. Sandman, Jr., M.D., Louisville (1970)
George A. Sehlinger, M.D., Louisville (1972)
John G. Stober, Sr., M.D., Louisville (1971)
John E. Trevey, M.D., Lexington (1971)
UK SAMA President, Mr. Paul S. Armstrong, Lexington
UL SAMA President, Mr. Allen Tonkin, Louisville

McDowell House Board of Managers

Laman A. Gray, M.D., Louisville, Chairman
Robert C. Bateman, M.D., Danville
B. B. Baughman, M.D., Frankfort
Mr. Sterling Coke, Lexington
Mr. James L. Cogar, Harrodsburg
Mr. George Grider, Danville
Eugene H. Conner, M.D., Louisville
Blaine Lewis, Jr., M.D., Louisville
Richard H. Segnitz, M.D., Lexington
Doctor Earl P. Sloane, Lexington
Mr. Enos Swaine, Danville

Memorials Commission

Eugene H. Conner, M.D., Louisville, Chairman
D. P. Hall, M.D., Louisville
J. Duffy Hancock, M.D., Louisville
Francis M. Massie, M.D., Lexington
M. David Orrahood, M.D., Owensboro
James M. Stevenson, M.D., Brooksville

LEGISLATIVE ACTIVITIES

Committee on Legislative Activities

Hoyt D. Gardner, M.D., Louisville, Chairman, National Affairs
Fred C. Rainey, M.D., Elizabethtown, Chairman, State Affairs
Harold B. Barton, M.D., Corbin
C. Melvin Bernhard, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
David A. Hull, M.D., Lexington
John P. Stewart, M.D., Frankfort

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



Appearances may be deceiving



It may be tetracycline

but it's not ACHROMYCIN® V
Tetracycline HCl

unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines. *Warning:* In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. *Precautions:* Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

530-9



symptoms of mixed anxiety-depression are rarely clear-cut..
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

COMMUNICATION AND PUBLIC SERVICE

Committee on Orientation

Carl Cooper, Jr., M.D., Bedford, Co-chairman
C. Wyatt Norvell, M.D., New Castle, Co-chairman
Glenn F. Baird, M.D., Florence
Winston L. Burke, M.D., Lexington
Robert C. Long, M.D., Louisville
Harvey A. Page, M.D., Pikeville

Committee on Health Careers

Joseph Hamburg, M.D., Lexington, Chairman
Mohammad Atik, M.D., Louisville
C. Wayne Franz, M.D., Ashland
Mrs. Rose Gardner, Louisville
Hal E. Houston, Jr., M.D., Murray

Committee on Community and Rural Health

John M. Baird, M.D., Danville, Chairman
William K. Keller, M.D., Louisville
Stephen B. Kelley, M.D., Somerset
Adam Miller, M.D., Lexington
George R. Tanner, M.D., Ft. Thomas
Jesse W. Tapp, M.D., Lexington
Thomas S. Wallace, Jr., M.D., Louisville

Committee on School Health, Physical Education & Medical Aspects of Sports

O. B. Murphy, M.D., Lexington, Chairman
Charles D. Clark, M.D., Murray
Guy C. Cunningham, M.D., Ashland
Samuel W. Gehring, M.D., Flemingsburg
Vaughn Lee Fisher, Jr., M.D., Bowling Green
Richard F. Greathouse, M.D., Louisville
William B. Haley, M.D., Paducah
Robert A. Hall, M.D., Paintsville
James K. Hurlocker, M.D., Harlan
Leslie W. Langley, M.D., Elizabethtown
V. Wayne Lowe, M.D., Madisonville
Noble T. MacFarlane, Jr., M.D., Lexington
Robert N. McLeod, M.D., Somerset
William A. McManus, M.D., Owensboro
James F. Siles, M.D., Covington
Alec Spencer, M.D., West Liberty
Ronald E. Waldridge, M.D., Shelbyville

Cults Committee

David B. Stevens, M.D., Lexington, Chairman
Morris M. Garrett, M.D., Covington
Harold D. Haller, M.D., Louisville
Martin Z. Kaplan, M.D., Louisville
Charles R. Rogers, M.D., Ashland
James G. Sills, M.D., Hardinsburg
James O. Willoughby, M.D., Bowling Green

Senior Day Committee

Hoyt D. Gardner, M.D., Louisville, Chairman
Walter I. Hume, Jr., M.D., Louisville
Richard B. McElvein, M.D., Lexington
Myron G. Sandifer, M.D., Lexington
Eugene H. Conner, M.D., Louisville
Jacqueline A. Noonan, M.D., Lexington
Ji-toong Ling, M.D., Louisville

Advisory Committee to Woman's Auxiliary

Henry B. Asman, M.D., Louisville, Chairman
George F. Brockman, M.D., Greenville
Robert E. Pennington, M.D., London

GOVERNMENTAL MEDICAL SERVICES

Coordinating Commission on Governmental Medical Services

Edward N. Maxwell, M.D., Louisville, Chairman
Marvin A. Bowers, Jr., M.D., Louisville
Thomson R. Bryant, Jr., M.D., Lexington
Frank M. Gaines, Jr., M.D., Louisville
Walter I. Hume, Jr., M.D., Louisville

Technical Advisory Committee on Physician Services (Title XIX)

Thomson R. Bryant, Jr., M.D., Lexington, Chairman
Wallas N. Bell, M.D., Sturgis
Lawrence U. Gilliam, M.D., Corbin
Robert T. Longshore, M.D., Covington
J. Sankey Williams, M.D., Nicholasville

Advisory Committee on Title XVIII (Social Security Act)

Edward N. Maxwell, M.D., Louisville, Chairman
James B. Cox, M.D., Hopkinsville
Irving F. Kanner, M.D., Lexington
W. A. Litzenberger, M.D., Elizabethtown
Robert E. Smith, M.D., Covington
Charles B. Spalding, M.D., Bardstown
Max E. Wheeler, M.D., Ashland

Claims & Utilization Review Committee

Marvin A. Bowers, Jr., M.D., Louisville, Chairman—Anethesia
W. Burford Davis, M.D., Louisville—Thoracic Surgery
Orville T. Evans, M.D., Lexington—Proctology
Stuart E. Harlowe, M.D., Louisville—Urology
Maurice Kaufmann, M.D., Lexington—Allergy
H. Burl Mack, M.D., Pewee Valley—General Practice
Roy A. Martin, M.D., Louisville—Otolaryngology
Andrew M. Moore, M.D., Lexington—Plastic and/or Reconstructive Surgery
Roy H. Moore, Jr., M.D., Louisville—General Surgery
M. David Orrahood, M.D., Owensboro—Pathology
Robert M. Runge, M.D., Covington—Orthopaedic Surgery
Harvey R. St. Clair, M.D., Louisville—Psychiatry
S. R. Scheen, M.D., Louisville—Dermatology and/or Syphilology
Ludwig H. Segerberg, M.D., Louisville—Neurology and/or Neurosurgery
James E. Skaggs, Jr., D.D.S., Louisville—Oral Surgery
Orson P. Smith, Jr., M.D., Louisville—Radiology
Edwin P. Solomon, M.D., Louisville—Obstetrics and/or Gynecology
Robert S. Tillett, M.D., Louisville—Internal Medicine
Faull S. Trover, M.D., Madisonville—Pediatrics
Charles F. Wilson, M.D., Pikeville—Ophthalmology

Committee on Appalachian and OEO Programs

Frank M. Gaines, Jr., M.D., Louisville, Chairman
James A. Baumgarten, M.D., Owensboro
Jesse Bell, M.D., Louisville
Harold L. Bushey, M.D., Barbourville
James A. Holbrook, M.D., Prestonsburg
Garner E. Robinson, M.D., Ashland
Walter H. Stepchuck, M.D., Evarts
Cordell H. Williams, M.D., Hazard
Harvey Sloane, M.D., Louisville

AD HOC COMMITTEES

Ad Hoc Committee on Comprehensive Health Planning

George F. Brockman, M.D., Greenville, Chairman
William W. Hall, M.D., Owensboro
Rex E. Hayes, M.D., Glasgow
Lee C. Hess, M.D., Florence
Andrew M. Moore, M.W., Lexington
Charles C. Rutledge, M.D., Hazard
George A. Sehlinger, M.D., Louisville

KMA-KNA Joint Advisory Committee

A. Evan Overstreet, M.D., Louisville, Physician's Chairman
Kenneth Crawford, M.D., Louisville
Frank M. Gaines, Jr., M.D., Louisville
Charles R. Perry, M.D., Covington
Charles N. Tarkington, M.D., Lexington
Samuel D. Weakley, Jr., M.D., Louisville
Tom F. Whayne, M.D., Lexington

Ad Hoc Committee to Study the Problem of Occupational Pulmonary Disease

John E. Eckerle, M.D., Louisville, Chairman
William H. Anderson, M.D., Louisville
Mitchel B. Denham, M.D., Maysville
William C. Hambley, M.D., Pikeville
Joseph H. Humpert, Lakeside Park
Edward N. Maxwell, M.D., Louisville
J. Kent Trinkle, M.D., Lexington

Ad Hoc Committee on Finance

Henry B. Asman, M.D., Louisville, Chairman
George F. Brockman, M.D., Greenville
Ballard W. Cassady, M.D., Pikeville
Lee C. Hess, M.D., Florence
Keith P. Smith, M.D., Corbin

Committee on Air and Water Pollution

(to be appointed)

Special Medicine and Religion Representative to AMA

J. Campbell Cantrill, M.D., Georgetown

SAMA Representatives

University of Louisville—
Hoyt D. Gardner, M.D., Louisville
University of Kentucky—
Donald Edger, M.D., Lexington

Twelfth Norton Seminar To Be Held Dec. 18

Norton Memorial Infirmary will hold its Twelfth Annual Medical Seminar on December 18, according to James R. Peterdorf, vice-president of the Infirmary.

"Thyroid-Parathyroid" will be the theme of the day-long session, in which hospital staff members and other physicians will participate.

Guest speaker for the program will be James A. Pittman, M.D., director, division of endocrinology and metabolism, University of Alabama, Birmingham. Doctor Pittman will speak on "Thyroid Nodules and Cancer" and "Graves Disease: It's Nature and Treatment."

1970 Officers Elected At Annual MLA Meeting

Elliott H. Morse, librarian, College of Physicians of Philadelphia, was elected president of the Medical Library Association during its Annual Meeting in Louisville, October 26-30.

Other officers elected were Donald Washburn, director, Bureau of Library and Indexing Service, American Dental Association, vice president and president-elect; Sylvia Haabala, reference librarian, Mayo Clinic, secretary, and Ann E. Kerker, librarian, School of Veterinary Medicine, Purdue University, treasurer.

The 1970 Annual Meeting of the Medical Library Association will be held in New Orleans, May 17-22.

Rural Health Conference Set April 9-10 in Milwaukee

"Let's Put *you* in Comm-U-nity Health" is the theme for the 23rd National Conference on Rural Health to be held April 9-10 at the Pfister Hotel and Tower, Milwaukee, Wisc.

Clifford M. Hardin, Ph.D., Secretary of Agriculture, will deliver the keynote address, "The Challenge for Rural America" at the two-day session which is sponsored by the Council on Rural Health of the American Medical Association.

Other participants will deal with the impact of drugs and student unrest on health, meeting the health needs of the rural poor, emergency medical services and pollution's effect on America.

Public Health Assn. Elects Two

Charles F. Blankenship, M.D., Frankfort, was elected chairman of the Kentucky Association of Public Health Physicians at a September 25 meeting during the KMA Annual Session. Margaret A. Limper, M.D., Louisville, was named secretary of the specialty group. A vice president will be elected at a later meeting.

In Memoriam

TRACY I. DOTY, M.D.
Pikeville
1902-1969

Tracy I. Doty, M.D., 67, a general practitioner from Pikeville, died August 23. Death was attributed to a coronary thrombosis. Doctor Doty graduated in 1927 from the University of Louisville Medical School.

JOHN P. GENTILE, M.D.
Jeffersonville, Ind.
1900-1969

John P. Gentile, M.D., 69, health officer for the New Albany-Floyd County Health Department, died September 28 in New Albany. Doctor Gentile, a 1926 graduate of the Louisville Medical College, was secretary of the New Albany Board of Health in 1937, then became head of the New Albany-Floyd County Health Department in 1964. In World War II he served four years as an Army physician. He is a former president of the Floyd County Tuberculosis Association.

HENRY C. BURKHART, M.D.
Harlan
1899-1969

Henry C. Burkhart, M.D., 69, a general practitioner in Harlan since 1929, died September 29. Death was attributed to arteriosclerotic heart disease. A 1928 graduate of the Chicago Medical School, Doctor Burkhart was a member of the Southern Medical Association, Kentucky Academy of General Practice and American Academy of General Practice.

Percutaneous—Weakley and Mays

(Continued from page 906)

puncture of the subclavian vein avoids the antecubital cutdown and expedites the monitoring of central venous pressure. It allows patients freedom of movement, thus promoting their comfort and recovery.

The authors are grateful to Drs. Ted. Lynch, Sam Smith, Sam, Evan and Robert Overstreet who allowed their patients to be utilized in this project. (Cases 1 & 2).

Generic and Trade Name of Drugs

Sodium cephalothin—Keflin
hydrocortisone sodium succinate—Solu Cortef.
deslanoside—Cedil anid-D
nandrolone phenpropionate—Durabolin

References

1. Moran, J. M., Atwood, R. P. and Rowe, M. I.: Clinical and bacteriological study of infections associated with venous cutdown. *New Eng. J. Med., 272*:554-560, March 18, 1965.
2. Druskin, M. S. and Siegel, P. P.: Bacterial contamination of indwelling intravenous polyethylene catheters. *J.A.M.A., 185:* 966-968, Sept. 21, 1963.
3. O'Neill, J. A., Pruitt, B. A., Foley, F. D. and Moncrief, J. A.: Suppurative thrombophlebitis—a lethal complication of intravenous therapy. *J. Trauma, 8*:256-266, March, 1967.
4. Aubainac, R. L.: Injection intraveineuse sous claircirlaire: Advantages and technique. *Presse Med., 60*:1456, Oct. 25, 1952.
5. Christensen, K. H., Nerstrom, B. and Baden, H.: Complications of Percutaneous Catheterization of the Subclavian Vein in 129 Cases, *Acta Chir. Scand., 133*:615-62, 1967.
6. Smith, B. E., Modell, J. H., Gaub, M. L., and Moya, F.: Complications of Subclavian vein Catheterization. *Arch. Surg., 90*:228-229, Feb., 1965.
7. Davis, W. S. and Akers, D. R.: Catheterization of the subclavian vein. An unusual complication. *Rocky Mount. Med., 64*:72-73, Feb., 1967.



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM® Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220
A·H·ROBINS

KMA Committee Reports

Claims and Utilization Review Committee

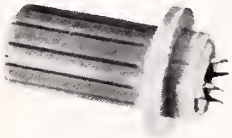
Marvin A. Bowers, Jr., M.D., Louisville, Chairman

KMA Headquarters Office **October 30, 1969**

The KMA Claims and Utilization Review Committee held its first meeting of the Associational year on October 30, 1969. Members of the Advisory Committee on Title XVIII and the Technical Advisory Committee on Physician Services (Title XIX) were invited as guests to the meeting. Also invited were: Mr. Donald R. Smith, Manager of the Medicare Office, Metropolitan Life, Lexington; Claude M. Eberhart, M.D., Associate Medical Director, Metropolitan Life, New York; Mr. Charles Parker, Chairman of the Kentucky Health Insurance Council and representative of Travelers Insurance Company, Louisville; Mr. Bruce McKinney, Supervisor of Part B, Medicare, Railroad Retirement Board of Beneficiaries, Travelers Insurance Company, Louisville; Mr. Francis Batridge, Metropolitan Life Insurance Company, Louisville; and Mr. Tom Stroud, Medicare Division, Kentucky Physicians Mutual, Inc., Louisville.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

Committee on Educational Television

Thomas L. Heavern, Jr., M.D., Highland Heights, Chairman

KMA Headquarters Office **November 5, 1969**

The KMA Educational Television Committee met recently to make plans for the next PANMED program schedule. Beginning in January, the second phase of the medically oriented program series will be broadcast over the Kentucky Educational Television Network. Included on the 13 program series are two programs on cancer and two on heart disease.

The next physician-oriented program will be "Clinical Use of Cardiac Pacemakers" and will be shown throughout on the KETV Network at 9:30 p.m., Wednesday, January 7, 1970, and in the Louisville area over Channel 15 at 10:00 p.m., January 12, 1970.

Scientific Program Committee

Allan M. Lansing, M.D., Louisville, Chairman

KMA Headquarters Office **November 5, 1969**

The Scientific Program Committee met recently to plan the General Scientific Sessions for the 1970 KMA Annual Meeting. The program this year will consist of a blend of individual presentations, panel discussions and a film, and the popular "Crackerbarrel Session" will be repeated again this year.

The chairman of the Scientific Program Committee and KMA President, Walter L. Cawood, M.D., will meet with the sixteen specialty groups that cooperate in the annual meeting on Thursday, December 18, to plan their section of the program.

Hydroxyurea—Yarbro and Leavell

(Continued from page 901)

17. Colsky, J., Greenspan, E. M., and Warren, T. N. Hepatic Fibrosis in Children with Acute Leukemia after Therapy with Folic Acid Antagonists. *Arch. Path. 59:*198-206, 1955.

18. Hutter, R. V. P. *et al.* Hepatic Fibrosis in Children with Acute Leukemia. *Cancer. 13:*288-307, 1960.

19. Coe, R. O., and Bull, F.E. Cirrhosis Associated with Methotrexate Treatment of Psoriasis. *J.A.M.A. 206:*1515-1520, 1968.

20. Haim, S., and Alroy, G. Methotrexate in Psoriasis. *1:* 1165, 1967.

21. Dresler, W. F. C., and Stein, R. Uber den Hydroxylharnstaff. Justus Liebig's *Ann. Chem. Pharm. 150:*242-252, 1869.

22. Kennedy, B. J., and Yarbro, J. W. Metabolic and Therapeutic Effects of Hydroxyurea in Chronic Myelogenous Leukemia. *J.A.M.A. 195:*1038-1043, 1966.

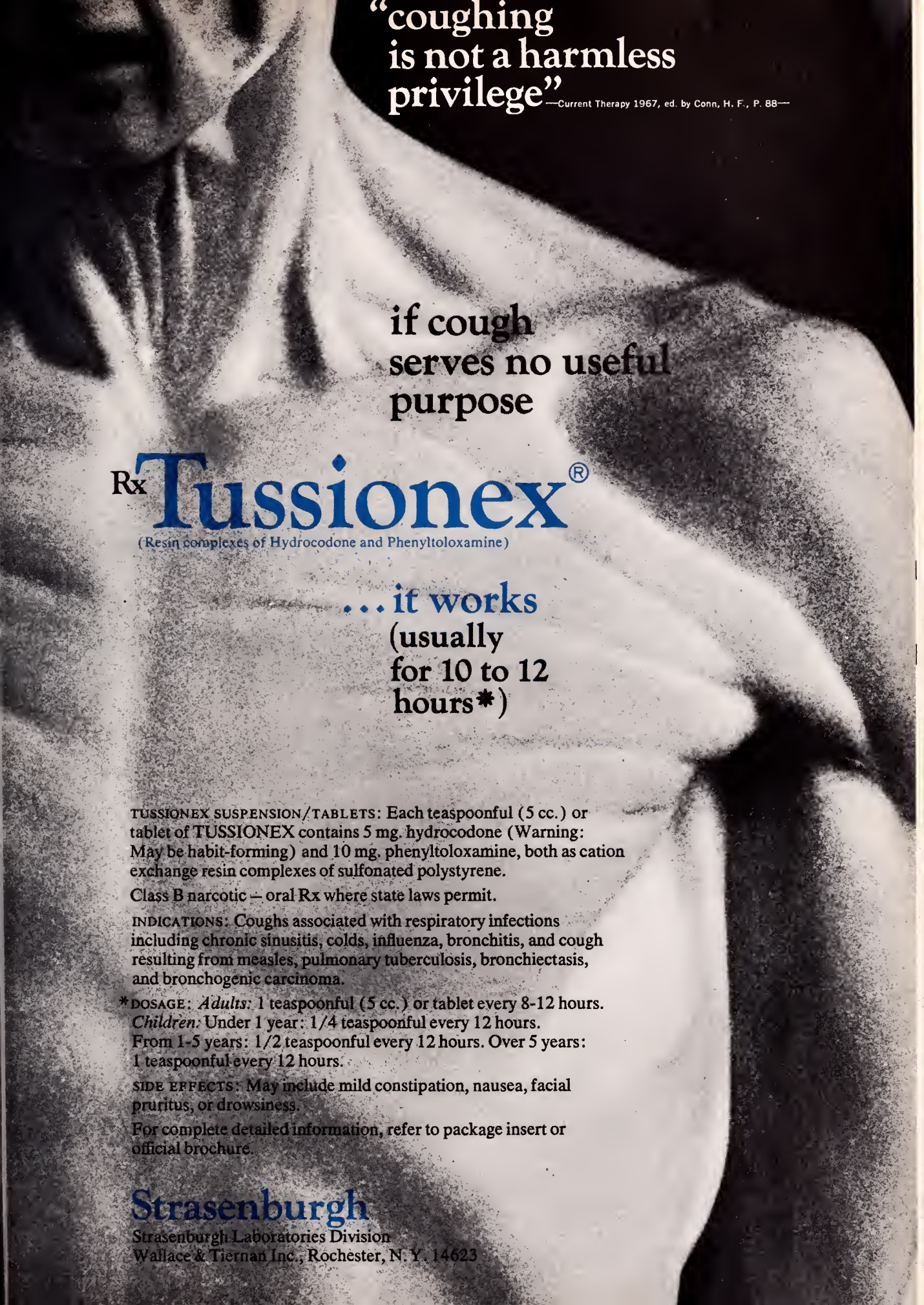
23. Yarbro, J. W., Kennedy, B. J., and Barnum, C. P. Hydroxyurea Inhibition of DNA Synthesis in Ascites Tumor. *Proc. Nat. Acad.Sci. 53:*1033-1035, 1965.

24. Kennedy, B. J., and Yarbro, J. W. Hydroxyurea in Chronic Myelogenous Leukemia. *Trans .Assoc. Am. Phy. 78:* 391-399, 1965.

25. Yarbro, J. W. Unpublished Observations.

26. Weinstein, G. D., and Van Scott, E. J. A.M.A. Annual Convention, New York, 1965.

27. Smith, H. C., Boutwell, R. K., Potter, V. R. Effects of Hydroxyurea on DNA and RNA Synthesis in Normal Skin Liver and Thymus. *Can. Res. 28:*2217-2227, 1968.



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic – oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

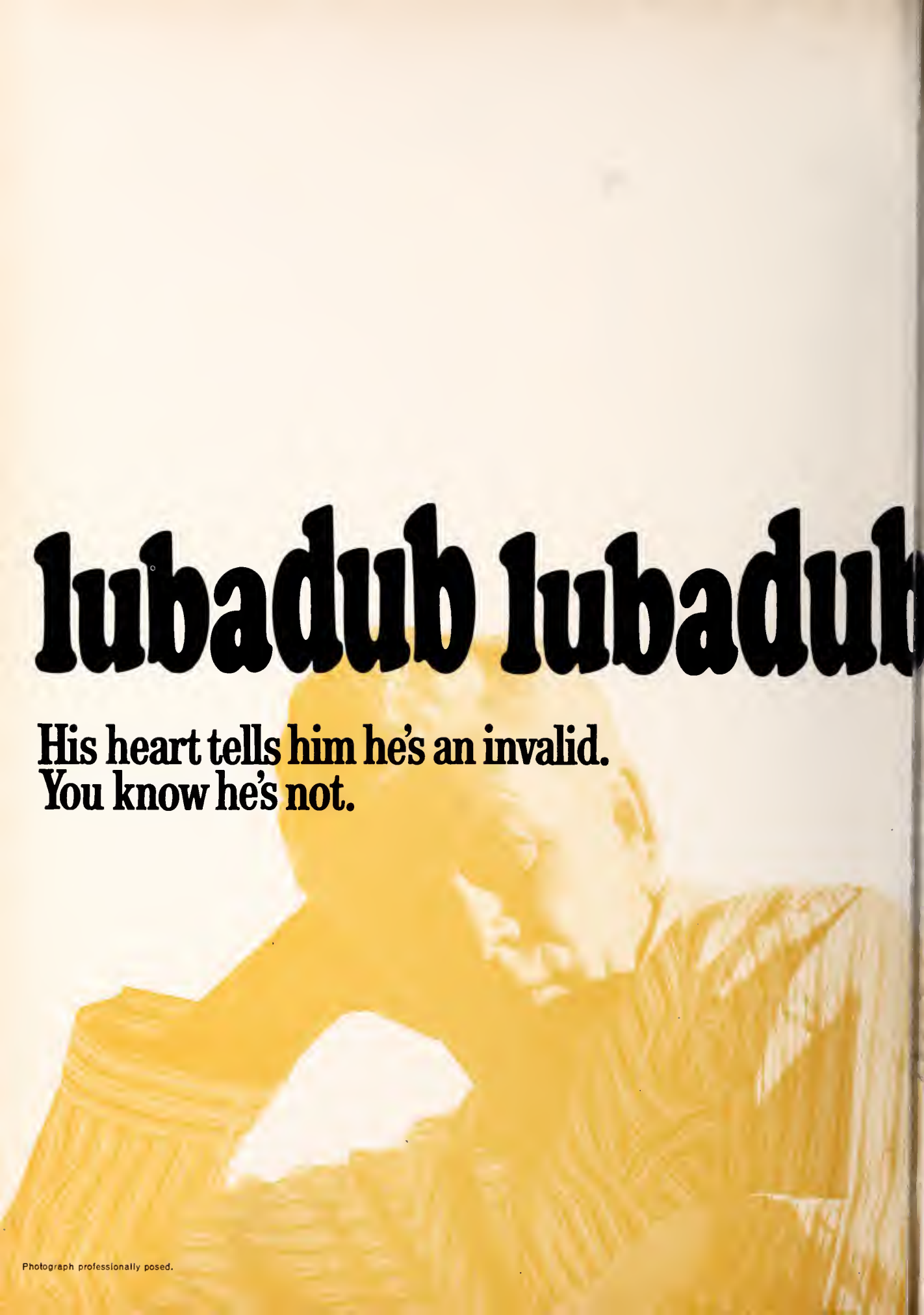
For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®

ibadubdub lubadu

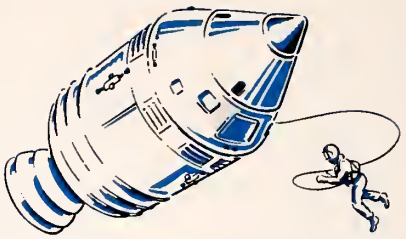
nxiety is expected in the cardiovascular patient.
little may even be desirable.

ut when anxiety is exaggerated . . . when it
iterferes with sleep . . . when it aggravates
ardiovascular symptoms, your help may
e needed.

aturally, you'll want to reassure the patient.

nd perhaps prescribe Equanil (meprobamate)
s adjunctive therapy. It helps relieve anxiety
nd tension specifically, yet gently.

lmost 15 years' use has shown that Equanil
usually well tolerated as well as effective.
ide effects are generally limited to transient
owsiness; serious, therapy-interrupting
de effects are rare.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

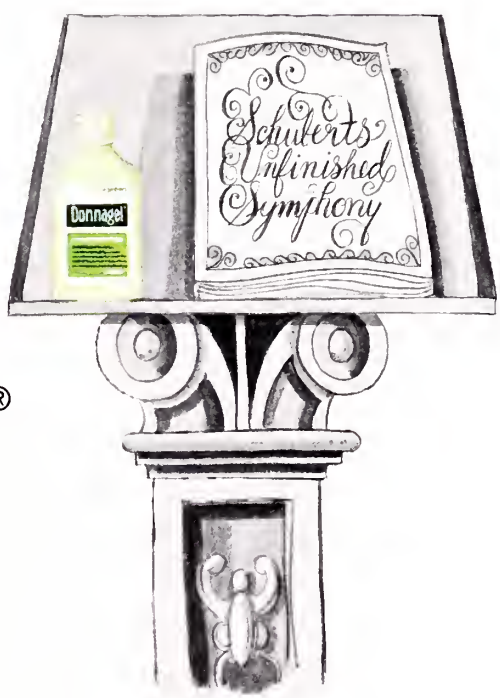
Manufacturers of Ethical Pharmaceuticals



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can ike at the most inopportune time, it takes a comprehensive agent to treat the al diarrheal syndrome and help get the patient back on the job. That's why many physicians rely on Donnagel, especially during the fall and winter nths when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. also contains the belladonna alkaloids to calm GI hypermotility and help ieve the distressing discomforts which so often accompany diarrhea. Certainly less expensive and more convenient than taking two medications. And the age is lower too. Available in the handy 4-oz. plastic bottle at pharmacies rywhere on your prescription or recommendation.



· Diarrhea and its Discomforts

Donnagel®

ch fluid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; lium benzoate (preservative), 60 mg.; Alcohol, 3.8%.

H·ROBINS A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220



PHOTO BY VICTOR



CLEAR THE TRACT!

THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control
ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Dextromethorphan hydrobromide 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate . . 7.5 mg.
Codeine phosphate . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Phenylephrine hydrochloride. 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"
COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
Dextromethorphan hydrobromide 7.5 mg.

Use this handy guide to pick the right formulation for each coughing need

	Robitussin	Robitussin-DM	Robitussin A-C	Robitussin-PE	Cough Calmers
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●		●
Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
Non-narcotic	●	●		●	●

A·H·ROBINS A. H. Robins Company, Richmond, Va. 23220

1969 CONSTITUTION AND BYLAWS
OF THE
KENTUCKY MEDICAL ASSOCIATION

Revised September 24, 1969

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, a Vice President, a Secretary, a Treasurer, a Speaker and Vice Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

Section 2. The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into eight classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Service, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

(3) Osteopathic physicians who practice allopathic medicine.

Associate members shall not have the right to vote

nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Service Members. Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(g) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(h) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

Section 5. Every new active member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component society, and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any

such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

Section 6. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 7. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 8. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 9. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 10. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 11. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 12. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 13. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 14. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 15. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 16. The state shall be divided into the following districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurels, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 17. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 18. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 19. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Section 1. The President-Elect and the Vice President shall be elected for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. The Vice President shall be elected from the same general area in which the president resides. Delegates to the AMA and their alternates shall be elected for terms of two years. The Speaker of the House of Delegates, the Vice Speaker, the Secretary, and the Treasurer shall be elected for terms of three years, but no member shall be eligible for election to more than two consecutive full terms as Secretary or Treasurer. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the committee. The committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. Before noon of the following day, the committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

Section 3. The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well-publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President shall succeed to the office of the President.

Section 4. The President-Elect and the Vice President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Director in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Director, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Director and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Director whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be

fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

Upon the complaint of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cases for disciplinary action exist. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to

notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary, ad hoc, committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $80, except Active Members who devote all of their time to teaching or research and have no private practice, $55; (2) Emeritus Members, no dues; (3) Associate Members, $10; (4) Inactive Members, $10; (5) Student Members, $1; (6) Service Members, no dues; (7) Special members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with

the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolutions, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 12 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful

orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

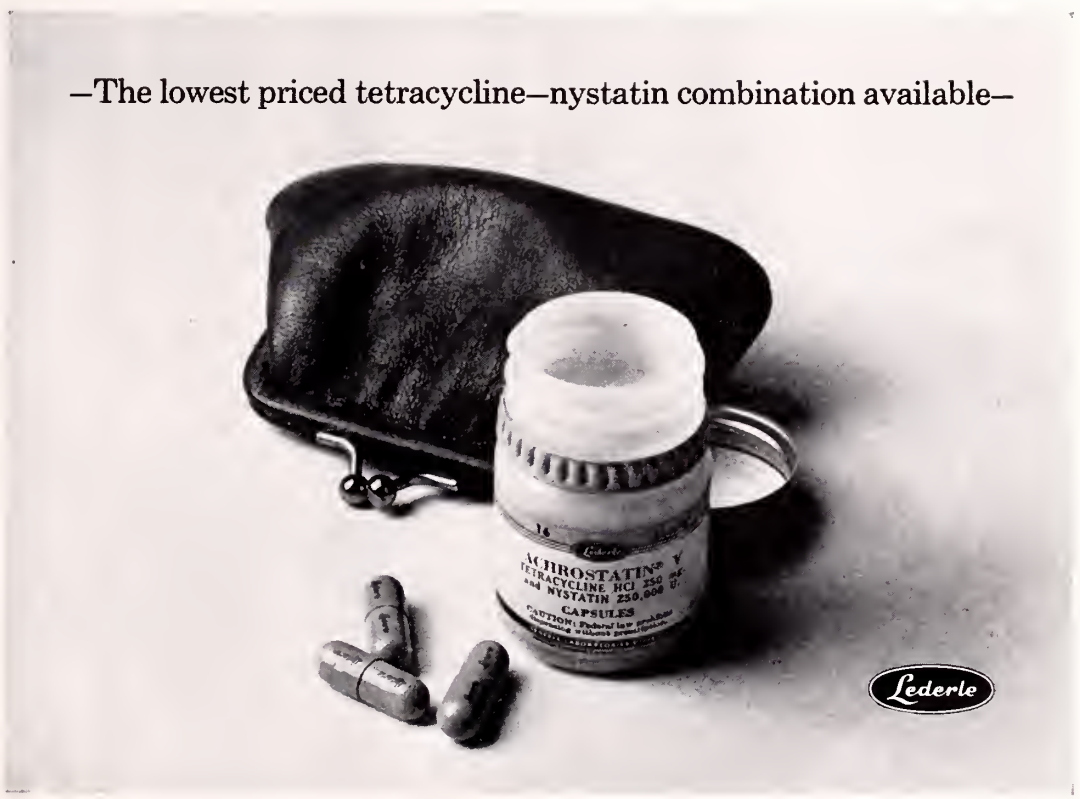
Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day, provided, however, that an amendment may be proposed in the report of a reference committee and considered by the House without having laid on the table for one day.



THE JOURNAL
of the
KENTUCKY MEDICAL ASSOCIATION

Index to Volume 67—1969

January	Pages 1 to 76	July	Pages 459 to 538
February	Pages 77 to 152	August	Pages 539 to 624
March	Pages 153 to 234	September	Pages 625 to 704
April	Pages 235 to 314	October	Pages 705 to 788
May	Pages 315 to 382	November	Pages 789 to 870
June	Pages 383 to 458	December	Pages 871 to 1000

Edited by Walter S. Coe, M.D.

Under the Supervision of the Board of Trustees

SCIENTIFIC ARTICLES

A

Anesthetics, An Evaluation of the Therapeutic Efficacy of Intravenous Local, 42
Asthma, Treatment of Childhood, 491

B

Botulism—A Case Report, 820

C

Cancer Chemotherapy, 565
Carcinoma of the Colon in Childhood, 895
Cardiac Pacemakers, An Unusual Complication in Permanent, 823
Cholecystectomies in a Small Community Hospital, A Study of, 420
Chronic Conditions in Kentucky, Estimated Prevalence of, 665
Chronic Disease Screening in a General Practice, 409
Cyanotic Heart Disease in Infants, Emergency Operation for, 413

D

Deaths in a Small Community Hospital, 749
Diabetic Children, Kentucky Camp for, 743

E

Empyema, Treatment of Non-Tuberculous, 40
Enteritis, Regional, and Chronic Ulcerative Colitis, 343
Eventration through Umbilical Hernia during Pregnancy, 110

F

Fibroplastic Endocarditis with Eosinphilia, 272
Flourescein Retinal Angiography As An Aid in Ocular Diagnosis, 185
Flurandrenolone Tape, 668

H

Health Knowledge Among Residents of a Rural Kentucky County, 113
Hemangioma of Spinal Canal, 825
Histoplasmosis, A Familiar Microepidemic of, 569
Hydroxyurea: A New Agent for the Management of Refractory Psoriasis, 899
Hyperadrenalism, The Genesis and Treatment of, 281

L

Laryngeal Blastomycosis, 53
Lung Cancer Patient, Pre- Intra- and Post-Operative Care of the, 191

N

Nurse Assistants, Extension of Medical Services through, 101

P

Paint-Thinner Sniffer, Case Report of a, 195
Percutaneous Catheterization of the Subclavian Vein in Various Clinical Situations, 902
"Phlebitis" and Arthritis, 107
Primary Inguinal Hernia Repair, 350
Prosthetic Heart Valves, What's New in, 352

R

Reye's Syndrome: An Association with Influenza A Infection, 269

S

Subarachnoid Hemorrhage, 752
Subtotal Gastrectomy Versus Vagotomy and Antrectomy, 659

T

Tetanus in the Bluegrass Area, 496
Tetanus Immunity Survey of Six-Year-Old Children, 817
Tracheobronchial and Esophageal Foreign Body Extraction in Infants and Children, 573
Tuberculosis Eradication . . . ?, 33

U

Urinary Tract Infection, Detection of Asymptomatic, 662

W

Whiplash Abdominal Injury, 501

AUTHORS OF SCIENTIFIC ARTICLES

B

Barbee, John Y., Jr., 185
Bard, James W., 668
Baughman, Branham B., 895
Beasley, W. B. Rogers, 101
Berardi, Romeo S., 350, 420, 501, 659, 749
Blacker, H. Martin, 752
Bosomworth, Peter P., 42
Broghamer, Walter L., 272
Bryant, Lester R., 352, 413

C

Clemons, Gil, 662

D

Dunbar, Ronald W., 42

E

Edwards, William C., 185

F

Fadell, Edward J., 53
French, Robert E., 743
Furcolow, Michael L., 496, 569, 817

G

Garison, Gary B., 823
Gaventa, William C., 272
Glenn, Frank, 281

H

Hall, Bryan D., 269
Hall, Mary A., 749
Haller, Harold D., Sr., 820
Handelman, N. I., 491
Hoffman, Franklin G., 272
Holland, Nancy H., 662
Hughes, Walter T., Jr., 269
Huth, Thomas, 191

I

Ildirim, Ibrahim, 496, 569, 817

J

Johnston, Coleman C., 343
Jurichs, Roger, 662

K

Kane, Robert L., 113, 409
Kmetz, Donald, 269
Kruegel, David L., 665

L

Leavell, Ullin W., 899
Lehn, Frank, 107

M

Macdonald, Roderick, Jr., 185
Makk, Laszlo, 825
Man, Pang L., 195
May, R. T., 820
Mayo, Porter, 40
Mays, E. Truman, 110, 902
McElvein, Richard B., 40
Meira, Affonso R., 496, 817

N

Nall, M. S., 491
Noonan, Jacqueline, A., 413
Norrell, Horace A., Jr., 752

O

Osborne, Mary, 107

P

Peak, William P., 107

R

Rainey, R. L., 823
Roth, Richard L., 820

S

Saliba, N. A., 33
Sanders, Neal, 743
Smiley, Gordon L., 825
Smith, Charles C., 53

T

Trinkle, J. Kent, 352, 413

U

Udhe, George 1., 53

V

Van Cader, Thomas, 185

W

Walker, J. Murray, Jr., 409
Weakley, Sam, Jr., 902
Welsh, Kenneth S., 569
Wilson, Charles B., 752
Wilson, Emery A., 113
Wright, Donald, 107

Y

Yarbro, J. W., 565, 899

SPECIAL ARTICLES

A

Adult Diabetes Mellitus, 203
AMA, Ever Done For You?, What Has, 55

B

Blue Shield's Partnership with Medicine, 362

C

CHP, 289
Clinical Associate, The, 677

H

Health Manpower—Mostly!, 427

M

Medical Credit Cards, 832
Medicare and Medicaid, More On, 582

O

OEO Programs in Kentucky: A Progress Report, 504

P

Presidential Address, 763

U

Usual and Customary Guidelines Approved, 122
Usual and Customary, House Takes Action on, 831

AUTHORS OF SPECIAL ARTICLES

A

Asman, Henry B., 763

B

Brockman, George F., 289

C

Coe, Walter S., 831

D

Dunlop, George, 362

E

Eichenberger, Ralph W., 677

H

Hendon, James Robert, 203

M

Moore, Roy, Jr., 122

W

Weihaupt, David B., 55
White, David, 203
Wood, Donald E., 427

EDITORIALS

A

Annual Meeting, 1969 KMA, 587

B

Board of Health, Proposed Changes for the, 841

C

Coquette, 128

D

Deans, Then and Now, 688

F

Face Lifting at Sixty-Six, A, 60
Fair Representation, 208

H

Health Careers in Kentucky, 208

K

Kentucky Medicine, 126

L

Learning Centers, 365
Long, Robert C., M.D., 907

M

Medicaid Today, 513
Medical Educational Television Is Here, 907

N

Neglected Opportunity, 292
Nurse!, 127

P

Physician, The New, 772

S

S.M.A. in Atlanta, The, 773

T

Thank You, A, 908
Tuberculosis Eradication in Kentucky, 59

U

Ulcerative Disease of the Bowel, 432

AUTHORS OF EDITORIALS

C

Coe, Walter S., 60, 365, 587, 772, 907, 908

H

Hamburg, Joseph, 208
Heavern, Thomas L., Jr., 907

M

Mardis, R. E., 59

O

Overstreet, Sam A., 208, 292, 432, 513, 688, 773, 841

SPECIAL FEATURES

B

Baker, Everett H., M.D., In Memoriam, 840

D

Digest of Proceedings, 1969 House of Delegates, 914

G

Gaither, J. Gant, M.D., In Memoriam, 129

H

Howard, E. M., M.D., In Memoriam, 293

K

KMA Annual Meeting Section, 593-616
KMA Constitution and Bylaws, 984
KMA Interim Meeting Program, 1969, 133
KMA Organization Chart, 24

ORGANIZATION SECTION

A

ASC Sectional Meeting To Be in Louisville, Feb. 24-26, 68
AMA/AMPAC Seminar, 18-member Ky. Delegation Attends, 526
AMA Approves 2-Year Curriculum for Medical Assistants, 780
AMA Committee Appointments Include Eight Ky. Doctors, 134
AMA Delegates at Annual Session Consider 196 Business Items, 693
AMA House Acts on 94 Matters During Clinical Convention, 68
AMA House Adopts Resolutions on Nursing Education, 449
AMA Lists 73 Kentucky Physicians at Annual Convention in New York, 694
AMA To Hold 118th Convention in New York July 13-17, 367
Annual Meeting, Crackerbarrel Session, Luncheon Featured at, 693
Annual Meeting, Distinguished Guest Speakers to Appear on Scientific Program of, September 23-25 in Louisville, 366
Annual Meeting, Miscellaneous Meetings Planned During KMA, 695
Annual Meeting, Sept. 23-25, New Crackerbarrel Session, Panel Discussions to Highlight, 442
Annual Mtg., Sept. 23-25, Prominent National Authorities to Join Kentucky Physicians in Timely Discussion, 516
Annual Mtg., Scientific Program Outline Released for, 517
Asman, Dr. Bernard, 97, Dies, 1897 Graduate of UL Med School, 694
Auto Crash Research Program Enters Fifth Phase in Ky., 219
Auto Safety Award to Louisville VA Hospital, KMA Gives, 443
Auxiliary Installs Mrs. Gardner, Elects Mrs. Hornaday, 847
Awards Committee, KMA, to Accept Nominations at Interim Meeting, 132

B

Blue Shield, One-Millionth Member Enrolls in Ky., 526
Board of Trustees Minutes December 11-12, 1968, Digest of, 136
Board of Trustees, Digest of Proceedings, March 26, 1969, 374
Brockman, George F., M.D., To Head TB Study Group, 446

C

Cancer Symposium, St. Joseph Infirmary to Hold June 23, 442
Chiropractic Available To Kentucky Physicians, Book On, 966
Congressmen, Know Your, 70
Continuing Medical Education Now Presented in TV Series, 779

F

Faculty Awards Presented to Drs. Bosomworth, Fishel, 852
First Trustee District to Meet January 22 in Paducah, 67
Florida Medical Deanship Goes to Ex-U.L. Dean, Dr. Smith, 852
Former KMA President Named as Blue Plans Director, 847

H

Hall, Dr., Named Board Chairman, Vice Chairman is Dr. Bryan, 845
Handley, Richard, Guest of Surgeons, To Speak at UL Symposium, 294
Health Consultant Appt. Goes to Dr. Gradie Rowntree, 619
Heart Association Symposium Planned March 26-27, 135
HEW Chiropractic Report Summary Printed for Information, 296
House of Delegates Summary, KMA, 854

I

Immunization Week, Annual, Set May 4-10 in Kentucky, 295
Interim Meeting, KMA Finalizes Plans for 1969, 217
Interim Meeting, KMA, March 26-27 in Lexington, Governor Nunn to Deliver Keynote Address at, 67
Interim Meeting, Record Attendance Reported at 1969, 368
Interim Meeting to Feature Discussions of Health Manpower, Comprehensive Health Planning March 26-27, in Lexington, 132

J

Johnson, Doctor Sidney, Lecture to Honor, 779

K

KAGP Elects Dr. Roach, Honors Dr. Seeley, 443
KAGP Plans 18th Annual Meeting May 6-10 in Louisville, 294
KEMPAC Invites U.S. Congressmen to Speak at Annual Seminar, 526
KEMPAC Physicians Hear Views of Two U.S. Senators At Seminar, 846
Ky. Hospital Association, Mr. Frazier Named Pres.-Elect of, 446
Kentucky Hospital Association to Meet April 21-24, 296
KMA Committees and Commissions for the 1969-70 Associational Year, 967
KMA Districts Hear Dr. Asman at Meetings, Fourth and Seventh, 218
KMA Surpasses 2400 Mark with Addition of 22 New Members, 966
KMA's Top Awards, Two Physicians, One Layman Receive, 852
KMA Washington Dinner Hosts All Ky.'s U.S. Congressmen, 526
KNA Elects 1st President-Elect At 63rd Annual Convention, 966
KPA Names Glasgow Pharmacist President-Elect at July Mtg., 693
KSAMA Holds 7th Convention May 16-18 at Elizabethtown, 527
Ky. Surgeons Elect Dr. Clardy, Dr. Ray, 525
Ky. Thoracic Society Conference Features Lung Transplant, TB, 779

L

Lexington Clinic Conference Scheduled April 3, 135
Logan, Theodore E., D.M.D., Ky. Dentists Name President-Elect at Meeting, 367
Long Announces Candidacy for AMA President-Elect, 965
Luncheon Speaker Remarks on Current Political Thought, 847

M

Mahoney, Mr., Joins KMA Staff in Field Services Division, 218
McConnell To Speak At Interim Meeting, J. Ed, 965
Medical Assistants to Meet at Elizabethtown in May, 296
Membership, KMA Again Attains Record for 1969, 853
Membership, KMA Adds 28 Physicians to its, 780
MLA, 1970 Officers Elected At Annual Meeting, 974

O

OB-GYN Society Schedules Mtg. April 11-12 in Louisville, 218
Oral Cancer Symposium, U of L, to Be Presented February 8, 67
Orientation Course to Be Offered March 26, New Member, 134
Orientation Program, Fifty-Seven Physicians Attend Spring, 374

P

Pediatricians, Ky. Chapter, Plan 11th Annual Spring Meeting, 295
Peters Elected As KEMPAC Board Chairman, Dr. C. Kenneth, 966
Physical Fitness Award Given to Dr. Kelley of Somerset, 619
Physicians Placement Service, Opportunities Available Through, 620
President's Luncheon, KMA, Journalist to Address Physicians At, 443
Project MED-AID: MARCO, Doctors, Wives Urged to Help in, 136

Q

Quertermous, Dr., House Elects, Dr. Hull at Annual Mtg., 845

R

Radiology Symposium, UK, Topic to be Bone & Joint Disease, 217
Reception Planned During Mtg., Given By KMA and Auxiliary, 693
"Relative Value Studies" To Be Available October 1, 695
Rheumatic Diseases Conf., UL, Arthritis Foundation Plan, 217

S

Scholarship Fund Grants Loans to 35 Medical Students, 527
Seeley Represents KMA At USP Conference Oct. 20, Dr., 966
Senior Day Program to Feature Completely Redesigned Format, 134
SMA Convention, Ky. Physician Attendance High at Annual, 68
Spangler, Phillip R., Named to Head Ky. Public Health Assn., 367
Surgeons to Hold Joint Mtg. May 16-17 in Somerset, 294

T

TB Organizations, Kentucky, Plan Meetings April 23 and 24, 296
Transplant Surgeon to Deliver L. E. Smith Lecture, Nov. 6, 779
Trustee Districts Plan Spring Meetings, Six KMA, 217
Trustee Districts To Meet During May and June, Seven, 366
Trustee Districts, All 15 KMA, Hold Meetings in '68-'69, 525
Twelfth Norton Seminar To Be Held Dec. 18, 974

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

LEASING
TAILORED FOR
Doctors!

The quickest, easiest, most economical way to acquire a car.

Conserve your precious time and keep your cash!

Let us do your
Car shopping for you!
(Any make or model)

WE ALSO LEASE
Medical & Surgical Equipment and Office Furnishings

Why Make a Capital Investment?

General LEASING
CORPORATION
A DIVISION OF KOSTER-SWOPE, INC.
3712 FRANKFORT AVENUE
Louisville—St. Matthews
897-1641 **895-2451**

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1969-70

Officers

WALTER L. CAWOOD, 1200 Bath Ave., Ashland (606) 325-1665 President
JOHN C. QUERTERMOUS, 205 S. Eighth St., Murray (502) 753-5161 President-Elect
HENRY B. ASMAN, 1169 Eastern Pkwy., Louisville (502) 454-4649 Immediate Past President
DAVID A. HULL, 2368 Nicholasville Rd., Lexington (606) 277-5711 Vice President
S. RANDOLPH SCHEEN, 1249 Medical Arts Bldg., Louisville (502) 451-1661 Secretary
KEITH P. SMITH, Medical Arts Bldg., Corbin (606) 528-3211 Treasurer
RICHARD F. GREATHOUSE, 5 Triangle Cen., Louisville (502) 458-3219 Speaker—House of Delegates
CARL COOPER, JR., Bedford (502) 255-3282 Vice-Speaker—House of Delegates
WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 Chairman of the Board of Trustees
THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 Vice-Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOS. GIANNINI, 1169 Eastern Pkwy., Louisville (502) 458-5315 Jan. 1969-Dec. 1970
CHAS. G. BRYANT, (Alt.) 1169 Eastern Pkwy., Louisville (502) 452-1558 ..Jan. 1969-Dec. 1970
GEORGE F. BROCKMAN, 2 East Main Cross, Greenville (502) 338-3660 ...Jan. 1970-Dec. 1971
DARYL P. HARVEY, (Alt.) Glasgow (502) 651-2133 Jan. 1970-Dec. 1971
CHAS. C. RUTLEDGE, Hazard Clinic, Hazard (606) 436-3121 Jan. 1970-Dec. 1971
DAVID B. STEVENS, (Alt.) 304 S. Limestone, Lexington (606) 254-8008 Jan. 1970-Dec. 1971

Trustees

1st District C. C. LOWRY, 104 N. Fifth St., Murray (502) 753-1340 1971
2nd District WILLIAM W. HALL, Mayfair Square, Owensboro (502) 684-6255 1970
3rd District THORNTON E. BRYAN, JR., Cadiz Clinic, Cadiz (502) 522-6673 1971
4th District W. BRUCE HAMILTON, 4th & Buckman, Shepherdsville (502) 543-6362 ..1971
5th District JOHN S. LLEWELLYN, 510 Heyburn Bldg., Louisville (502) 584-2173 1972
6th District PAUL J. PARKS, 1109 State St., Bowling Green (502) 842-0111 1972
7th District DONALD CHATHAM, 615 Washington St., Shelbyville (502) 633-3525 ..1970
8th District LEE C. HESS, 7211 U.S. 42, Florence (606) 371-1153 1972
9th District J. CAMPBELL CANTRILL, St. Luke Pl., Georgetown (502) 863-1231 1970
10th District ANDREW M. MOORE, 108 E. Maxwell, Lexington (606) 252-4406 1970
11th District DOUGLAS H. JENKINS, 527 W. Main, Richmond (606) 623-3751 1972
12th District ROBERT N. McLEOD, JR., 500 Bourne Ave., Somerset (606) 678-8155 ...1971
13th District PAUL E. HOLBROOK, 2nd National Bank Bldg., Ashland (606) 324-1616 ..1970
14th District BALLARD W. CASSADY, Pikeville (606) 437-6698 1971
15th District E. C. SEELEY, Medical Arts Bldg., London (606) 864-2357 1972

BUYERS GUIDE

DECEMBER BUYERS GUIDE FOR JOURNAL OF KMA 1969

Arch Laboratories 997
Arnar-Stone Laboratories 960

Burroughs Wellcame Company 964

Cabell Huntingtan Hospital 887
Campbell Soup Company 909

General Leasing 997
Glenbraak Laboratories 889

Highland Hospital 879
Hynsan Westcatt & Dunning, Inc. 873

Lederle Laboratories 875, 976, 993
Lilly, Eli & Company 894

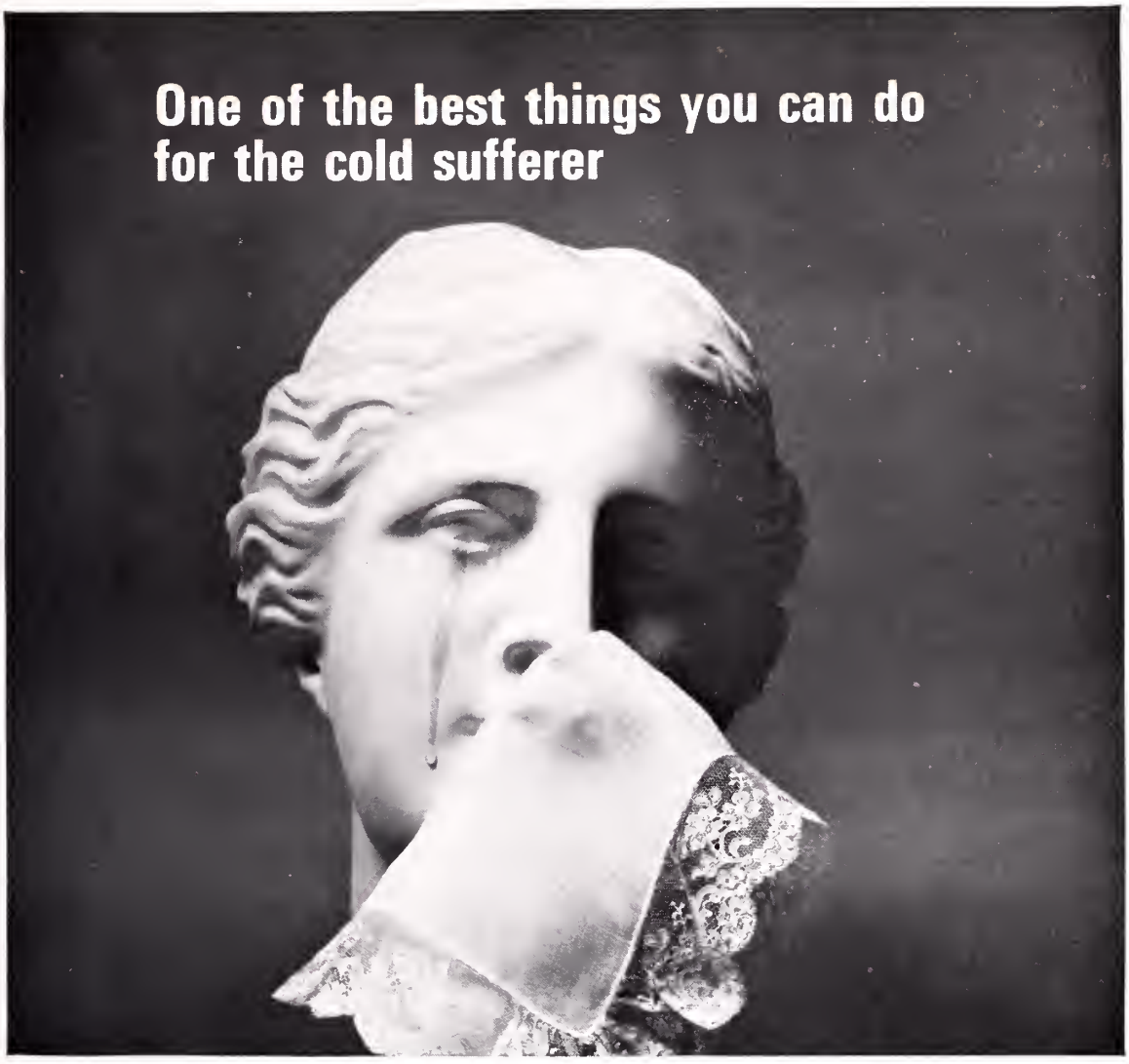
Medical Protective Company 959

Parke-Davis and Company 912, 969
Pfizer Laboratories 892-893
Paythress, Wm. P. Company 980

Riker Laboratories 886-887
Rabins, A. H. Company 975, 981-983
Rache Laboratories 890-891, 961-963, 1000

Sandaz Pharmaceuticals, Inc. 972
Searle, G. D. & Company 910-911
Smith, Kline & French 999
Sauthern Optical 879
Strasenburgh Labaratories 977
Stuart Company 872

Wyeth Laboratories 880-881, 978-979



Ornade® Spansule®

brand of
sustained release capsules

Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

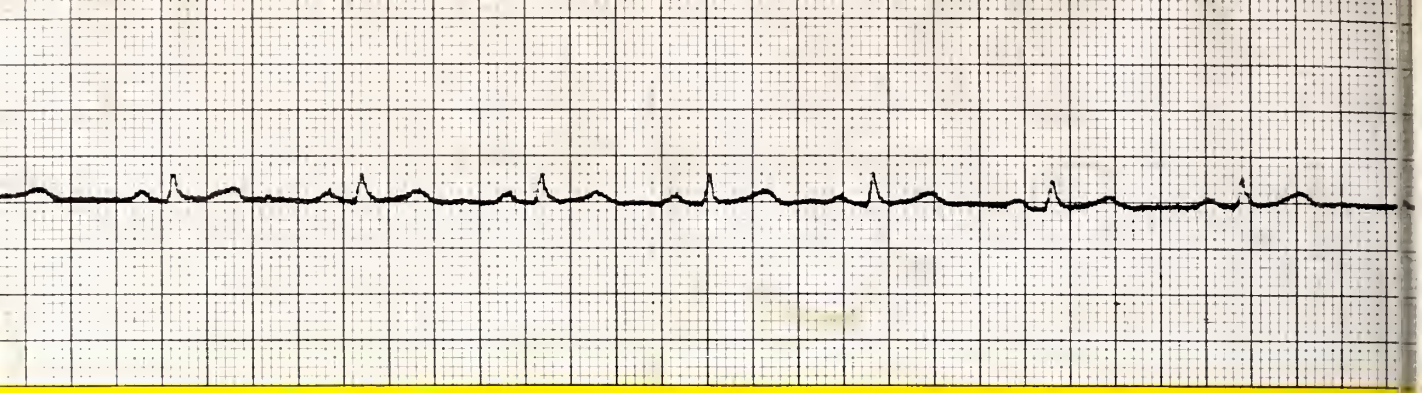
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

SK&F **Smith Kline & French Laboratories**



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. No further preliminary notice will be sent. Requests for renewals must be made on or before the date of expiration.

DUE	DUE

A fine of twenty-five cents will be charged for each week or fraction of a week the book is retained without the Library's authorization.